

**AUTONOMY ERODED? CHANGING
DISCOURSES IN THE EDUCATION
OF HEALTH AND COMMUNITY
CARE PROFESSIONALS**



Dr Ivan KOPPEL

**Institute of Education
University of London**

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ABSTRACT

The last decade of the 20th century saw unprecedented changes in the organisation of health and community care services in the UK. A substantial change occurred in the roles and functions of professionals. Continuing professional education (CPE) became more pivotal and within that interprofessional education (IPE) gained prominence, on the assumption that it promoted interprofessional collaboration.

The crucial elements in this process were the changes in the distribution of power between the stakeholder groups in professional education and the associated shifts in the discourses. The most noticeable background change has been in the transfer of power in the running of the welfare state from the professional to the management group. This thesis argues that this has led to much closer control by management of professional behaviour. The control is actualised through increased emphasis on teamwork, a tighter governance of CPE and the promotion of IPE. Guidance for professional development comes no longer from within the individual concerned but is superimposed from above. Yesterday's takers of initiatives have, perforce, become today's followers of orders.

It is further maintained that alongside the changes in power distribution there has been a shift in balance between the prevalent discourses. A rhetoric of co-operation exists between the key stakeholders - managers, educators and professionals - yet each group holds its own construction of the professional and consequently the education that is requisite. Thus, managers want professionals capable of providing an efficient service, educators wish to promote adult learners capable of change, and professionals themselves wish to promote their independence and self-governance. Professionals are insufficiently aware of these differences in perspective. They need to be alert to threats to their autonomy in the face of the managerial 'efficiency ethos' - since losing autonomy is arguably neither in their interests nor those of their clients.

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ABBREVIATIONS

ACT	Anticipatory Care Teams
APEL	Assessment of Prior Experiential Learning
APL	Assessment of Prior Learning
BMA	British Medical Association
CAIPE	National Centre for Advancement of Interprofessional Education in Primary Care
CATS	Credit Accumulation Transfer System
CBA	Controlled Before and After study
CCETSW	Central Council for the Education and Training in Social Work
CETHV	Council for Education and Training of Health Visitors
CONCAH	Continuing Care at Home
CME	Continuing Medical Education
CPE	Continuing Professional Education
CPD	Continuing Professional Development
CPN	Community Psychiatric Nurse
CVCP	Committee of Vice-Chancellors and Principals
DfEE	Department for Education and Employment
DHSS	Department of Health and Social Security
DN	District Nurse
DoH	Department of Health
ENB	English National Board for Nursing, Midwifery and Health Visiting
FHSA	Family Health Services Authority
GMC	General Medical Council
GMSC	General Medical Services Committee
GNC	General Nursing Council
GP	General Practitioner
HA	Health Authority
HE	Higher Education
HEPC	Higher Education Funding Council
HV	Health Visitor
ITS	Interrupted Time Series study
IPE	Interprofessional Education
LIZEI	London Initiative Zone Educational Initiatives
MCE	Mandatory Continuing Education
MPE	Multiprofessional Education

MW	Midwife
NHSE	National Health Service Executive
NVQ	National Vocational Qualification
NVQC	National Vocational Qualification Council
PADNT	Panel of Assessors for District Nurse Training
PAMs	Professions Allied to Medicine
PEP	Personal Education Plan
PDP	Personal Development Plan
PGEA	Postgraduate Education Allowance
PN	Practice Nurse
PPDP	Practice Professional Developmental Plans
PREP	Post-Registration Education and Practice
QA	Quality Assurance
QAA	Quality Assurance Agency
RCT	Randomised Controlled Trial
RCGP	Royal College of General Practitioners
SMAC	Standing Medical Advisory Committee
SCOPME	Standing Committee for Postgraduate Medical and Dental Education
TQM	Total Quality Management
UKCC	United Kingdom Central Council for Nurses, Midwives and Health Visitors
VFM	Value For Money
WBL	Work Based Learning

1 CHAPTER ONE - INTRODUCTION

1.1 WHY IS INTERPROFESSIONAL EDUCATION IMPORTANT?

The continuing professional education of health care professionals, including its aims, content and organisation has undergone massive changes in recent years. It has had to respond to substantial changes in the profile of professional work over the last 20 to 30 years, as professionals have taken on new responsibilities and are increasingly expected to be more accountable for their actions.

Collaboration between different professional groups in health and social care has been promoted over the last 30 years as a means of dealing with an increased complexity of care provision. It has been recognised that it is a near impossible task for a single professional group to take on the burden of care of people with diverse health and social needs. However, successful teamwork does not happen spontaneously - a number of preconditions have to be fulfilled in the work-place, including agreed aims and a supportive environment.

Interprofessional education (IPE) has been advocated as a structured way of fostering interprofessional understanding and developing collaborative skills. Can IPE fulfil these hopes? Is it capable of changing attitudes and working practices? Are these the only reasons why IPE has become more acceptable to policy makers, educators and professionals?

The mystery of interprofessional education policy-making

Working on the assumption that IPE is a worthwhile investment of financial and human resources, other questions arise. Under what conditions can it be successfully implemented? Can it be sustained, and what are the factors that facilitate this? And finally, who are the principal actors on the education scene and in the service organisations that play a decisive role in shaping continuing professional education and IPE?

The literature, as will be shown later, has a number of answers to most of the above questions, however incomplete these may appear. The major gap identified for this thesis is the last question - the question concerning the principal actors or stakeholders in the interprofessional education 'game'. The efforts and writings of the activists in this field such as Horder (1995) notwithstanding, no systematic work to date has been done in this area. Why is it important to gain an understanding of the processes of interaction between the stakeholders? I suggest that it is necessary to clarify the policy-making and implementation process in the complex environment of professional education,

where the government's intentions, service needs, professional interests and education sector involvement converge. What is the balance of arguments for and against changes to the organisation of professional education? Whose interests are served in supporting the development of IPE courses, and how is the process managed?

Thus, this line of enquiry begins to differ from other work within the IPE field that focussed primarily on the reasons inhibiting the introduction of IPE into the mainstream of CPE. While IPE in reality still constitutes a minor proportion of professionals' updating, it is worthwhile investigating the background to its increasing importance, the reasons behind it and how this change appears to be implemented.

Aims of the study

The four aims for this study emerge from the foregoing discussion.

1. To develop a **contextual framework** of the key issues relevant to an understanding of interprofessional education (IPE) and its place in continuing professional education/development (CPE/CPD). This requires building up a picture of the changing health care, teamwork and professional education scene.
2. To develop a **theoretical framework** for an analysis of empirical data exploring IPE and CPD and their relevant contexts.
3. To **critically evaluate** the emerging picture of the context of IPE and CPD on the basis of this theoretical framework.
4. To **investigate how IPE and CPD feature** in the thinking and practice of key players, who are identified as policy makers, educators, employers, and the professionals themselves.

This study will attempt to map the environment within which IPE is introduced and analyse the forces altering this environment. Empirical investigation is based on interviews with a number of actors in the educational scene, participant observation and analysis of relevant documents.

1.2 CHAPTER OUTLINES

Chapter Two - Background: Context of politics and policies in the NHS

I explore here background issues arising out of changes in the organisation of the NHS, and especially in primary health care, that contribute to altered priorities for CPE and its role in leading to the greater acceptance of IPE as a legitimate modality of learning. These include changing economic circumstances, alterations in political philosophy, the move towards managerialism in the Health Service, and changes in the power of the professions. A number of forces impact on the role, function and standing of various professional groups in the NHS. Changes in the public's expectations, the focus on patient-centred care, and the drive towards the employment of generic care workers free of professional allegiances, contribute towards the shifting of traditional professional positions.

Consideration of these factors will contribute to an understanding of the changing professional educational scene.

Chapter Three - Background: Review of interprofessional teamwork

I argue in this chapter that a detailed knowledge of teamwork issues is essential to further the understanding of how IPE has been conceptualised and what role IPE is seen to play in the promotion of teamwork.

Following a summary of the advantages and disadvantages of teamwork, the bulk of the chapter is concerned with identifying indicators for successful teamworking as well factors hindering it. Effectiveness will be seen to refer to outcomes for the practitioners and for patient care. This chapter concludes by listing key issues which have been found to help or obstruct effective teamworking. These fall into three categories: the context of the team, its structure and its function.

Chapter Four - Background: Review of CPE and IPE

This chapter focuses on CPE and IPE and their value in maintaining professional expertise in the fast developing world of improved technologies and changed societal demands. The nature of professional knowledge and the changes in professional responsibilities is explored in this context. The competency debate is touched on as it poses particular challenges to professional education.

The role of key stakeholders in CPE and IPE - the state, employers, education providers, the professions - are described. Particular attention is given to the development of their policies in these fields.

The arguments for and against the introduction of IPE is accompanied by questioning the value of such an undertaking. Who should assess the learning needs of an interprofessional nature, and how can this be done? What are the desired learning outcomes? The critical review of IPE addresses these issues. This is followed by an analysis of the evidence of outcomes of these activities.

Chapter Five - Theoretical perspectives

Four theoretical perspectives that aid the analysis and interpretation of empirical findings are outlined.

Firstly, issues of power are discussed as a way of understanding the relationships between stakeholders and as a basis for policy-making. Two models of power - pluralist and hegemonic - are used.

Secondly, the innovation perspective is offered to illuminate the background to change processes in a number of the domains outlined so far. There is a need to review the process of adoption of innovation both to understand the history of the process and to offer guidance for the future.

Thirdly, adult learning theory serves to throw light on those aspects of learning and teaching relevant to CPE and IPE. The concept of the adult learner is central to the field of CPE and IPE as professionals, by the nature of their work, have a considerable autonomy of action and need to rely on their judgment in managing the diverse challenges posed by their work.

The last theoretical perspective is poststructuralist. Foucault's concepts of discipline, examination and power-knowledge inform an analysis of power issues in the organisation of care and education. This framework also accounts for discourses and their interrelationships as mentioned in Chapter Eight. Within the same paradigm a critique of modern educational endeavour is outlined.

I wish to suggest that this multiple perspective offers an opportunity to analyse in a more integrative way the policy process and the behaviour of the stakeholders.

Chapter Six - Methodology

Data collection

Data for the study come from interviews, participant observation and documentation.

Twenty four subjects were interviewed initially representing the main stakeholder groups - the managers, educationalists and those from professional bodies. An additional eight interviews were conducted during the data analysis stage to obtain more focussed data.

Further data were obtained through a process of participant observation at meetings of various stakeholders. The documentation produced by them served as an additional, independent, source for analysis.

Data analysis

Two analytical methods are used - grounded theory method and discourse analysis. In this chapter I present an argument for my choice of these methods.

Discourse analysis draws on Foucault's conceptual framework. It is used to identify profiles of discourses and their use by the main stakeholders.

Results are not presented in an independent chapter, instead they are incorporated into the next two discussion chapters.

Chapter Seven - Discussion: Understanding the context for CPD and IPE

In this chapter I apply the two-fold analytical framework of power - pluralist/ hegemonic and poststructuralist - to the key issues in the NHS context and teamwork, including the policy-making process. One of the defining features of the current state of organisation of NHS and Community Care is the shift of power to the management group, and this is critically analysed. The same critical view, building on the above mentioned analytical framework, is applied to the role of CPD and IPE. The main questions are: whose interests are served by an increased reliance on these learning methods and what role do they play in the control of professional behaviour?

Chapter Eight - Discussion: Stakeholders in CPD and IPE and their discourses

Stakeholders in the education scene can be divided into:

- the policy makers and management group that includes the NHS Executive, health authorities, health care trusts and corporate purchasers of education;
- the professional group including professional bodies and professionals;
- the education group covering education organisations and educators as individuals.

The role of stakeholders in CPD and IPE are described. Attention is paid to their interactions and to issues of power that are central to such interactions.

I suggest here that the competing agendas of the different stakeholders, differing degrees of power and the ability to use it within their interactions, impact in a complex manner on the introduction and sustaining of IPE.

Three major discourses emerge: a discourse of management, a discourse of excellence and a discourse of adult learning. These are the predominant discourses of the three key stakeholder groups identified above.

- The policy-maker and management group aims for efficient service and thus it links education with service needs.
- The professional group is interested in maintaining and promoting the independence of professionals and education is designed to produce professionals intent on providing the highest standards of individual care.
- The education group is concerned with developing an autonomous, life-long learner.

Chapter Nine - Summary and conclusions

This chapter reviews lessons learned from the study by integrating the outcome of the different analytical strands. It is suggested that attention needs to be paid to teamwork and to CPD and IPE as interrelated activities, which may be seen as complementary aspects of practice and learning

throughout health care professionals' lives. However, there needs to be continuing debate about the role of the diverse stakeholders in influencing the content and organisation of CPD and IPE, and the influence they wish to have on their uptake by the professions.

Readers are invited to consider the findings, with the intention that such insights will allow them to critically approach the changing field of professional education.

Further recommendation is made about collaboration between stakeholders, and about the need to understand the prevalent discourses and their impact on the process of managing competing agendas.

Questions are raised about points for the future direction of research, as a number of questions remained unanswered. What are the shifts of meanings and how do these occur? What underpins the shifts of power between the stakeholder groups?

1.3 SUMMARY

This chapter has argued for the need to investigate the emerging modality of professional learning - interprofessional education. I have suggested that first there is a need to build up a substantive background of the contextual changes in the NHS and Community Care, and the reasons for the drive towards teamwork. I have also given an outline of the chapters to follow that document the research process and its outcomes.

Personal reflection

I need to point out at the outset that, however dispassionate I may have tried to be throughout the process of the research, I have become aware of the bias inherent in my position as a practising professional. In addition I am a member of a profession that I see is under threat from the proposed changes to the running of the Health Service and professional education. In fact, suspicions about these changes have been reinforced through my work. I will point out at the end different ways of interpreting the evidence and what my personal view is.

2 CHAPTER TWO - BACKGROUND: CONTEXT OF POLITICS AND POLICIES IN THE NHS

2.1 INTRODUCTION

Interprofessional and continuing professional education need to be located in the wider context of changes to the working lives of professionals in health and social care. What has been the origin of these changes? How much do these relate to the development of society and how much to altered government policies?

Three major drivers for change are discerned: changes in the welfare state, its organisation and function; changes in the professions; and the organisation of health and social care. These interrelated drivers for change provide a backdrop for understanding how policies on teamwork have developed over the last 30 years. How these impact on policy development of CPE and IPE is discussed later in Chapter Four.

The time framework described here is determined by the timescale of the research. As the principal phase of data collection terminated towards the end of 1996, only the policies up to that time are described here to provide a relevant contextual framework. Major changes in the political scene were introduced following the victory of the Labour Party on 1st May 1997. These are alluded to in the discussion in Chapters Seven and Eight to introduce an additional perspective on the conclusions reached in this work.

2.2 NHS CHANGES AND THE WELFARE STATE

The National Health Service has been the pride of the British welfare state since its inception in 1948. It has been built on the principles of equitable distribution of services and of free access at point of delivery. These principles of the welfare state arising from the socialist ideology of the Labour Party have been largely unchallenged by successive governments.

I will focus now on two major factors behind the changes in the NHS, namely the economy and altered concepts of the welfare state.

2.2.1 Economic considerations underlying the organisation of the NHS

The NHS has consistently showed itself to be an efficient organisation in comparison with other industrial countries in terms of the proportion of use of GDP expenditure. For example, the average proportion of GDP allocated to health in UK has been in the region of 6-7 percent, whilst in the USA it has reached up to 12 percent (Allsop, 1995).

However, the changing economic fortunes of the late 1980s affecting the industrial world coupled with the ideological drive of the Conservative Government, have produced an opportunity for radical changes. Health and social care have traditionally been a major consumer of state income and demands for increased expenditure have been growing progressively over the years. This can be ascribed to technological advances, to a more sophisticated and empowered population, and to demographic changes that brought a proportionately larger group of elderly into the remit of state care (Bennett & Fox, 1993).

Technological advances in medicine and public expectations

Scientific discoveries in medicine contribute to the development of new treatment techniques, new and more effective drugs and better equipment for diagnosis or treatment (Warner & Riley, 1994; Royal College of Physicians of London, 1995). The drive toward better care that these advances promise, is tempered by an awareness of associated escalating costs. The public expects more from the medical establishment - people are better informed and wish to participate in decision-making. They rightly feel that a considerable investment is worthwhile to prolong life or improve its quality of it, in the case of chronic or terminal diseases.

Demographic changes

Over the last hundred years in Western society the population profile has changed. People live longer due to improved social and housing conditions. Better hygiene, improved maternity and child care banished the spectre of deadly infectious diseases. The relative slowing-down of population growth, coupled with a growing number of people surviving to old age, means that the wage-earning base has diminished.

Other factors contributing to the increased demands being made on the Health Service include stresses associated with a loosening of traditional social ties and the increased proportion of single-

parent families. Ease of travel and a wish to escape poverty and internecine wars has resulted in a significant influx of ethnic minorities with their specific health and social care demands.

2.2.2 Ideological considerations and policies

Antecedents of changes in the NHS predate the 1970s, but attention here is focussed on the last thirty years as the concept of teamwork and IPE became much more intertwined with the policies and practice of key stakeholders influencing primary care i.e. RCGP and DoH.¹

The 1970s contain the seeds for understanding the subsequent changes in welfare state organisation. Labour Party policies dominated these years. The underlying principles were those of universal and comprehensive coverage and an assurance of adequate provision of essential services (Lowe, 1993).

The beginning of the move away from state control over the lives of individuals can be traced to these years. The NHS in the 1970s faced problems inherent in the collectivist philosophy of central command and control prevalent at the time. Rational planning of new hospitals and attempts to bolster community care in the 1960s were undermined by short-term political and economic needs, by inefficiencies at the implementation stage and factional interests of the medical profession and Local Authorities (Lowe, 1993).

The reforms of the NHS in 1974 (Department of Health and Social Security, 1971) were designed in fact to increase central control. For the first time planning and budgetary tools were introduced to increase efficiency and shift resources to priority groups such as the elderly and the mentally handicapped. These attempts at central control, however, were unsuccessful due to the complex management structure and the dominant voice of the medical hierarchy (Glennerster, 1995).

Social Services reforms (Department of Health and Social Security, 1970) reflected the wishes of the social work profession to establish itself as an independent and respected occupational group. Implementing these changes introduced new intricacies into the running of these services. The removal of social workers and community health staff from the remit of a Local Authority's Medical Officer of Health resulted in the loss of a co-ordinated approach to community health and social care needs.

¹ A more detailed treatment of this subject is provided by Lowe (1993), Glennerster (1995) and Leathard (1997).

An important break in the expansion of the welfare state came in 1976 with the onset of an economic crisis. This had a considerable impact on welfare spending - as Glennerster points out (Glennerster, 1995) (p165):

The share of the nation's resources going to social policy was to stabilize and then decline in the period from 1981 to 1990, the first time it happened in the twentieth century except as a consequence of a war.

Policies of the Labour Government had to change and an expansion of the economy had become a priority. The monetarist ideas of Friedman (1962), who advocated control of inflation as the primary role of government, began to inform political thinking. He promoted the idea of market forces as capable of regulating the economy more successfully than the government could. While these ideas became a central tenet of the Conservative Party, the Labour administration adopted measures to control public expenditure as a pragmatic solution to economic problems. It introduced for the first time cash limited budgets in most government departments. This proved to be a turning point and subsequent Conservative administrations built on this.

The victory of the Conservative Party in 1979 ushered in a new era in British politics. Many cherished ideas and policies of the welfare state were overturned or modified in line with new ideologies, now recognised as New Right (Lowe, 1993). The proponents of economic liberalism argue that the market encourages efficient use of scarce resources, and thus is able to address the inequalities by promoting economic growth. In addition, it promotes self-reliance and weans the citizens from dependency on the State. These ideas justified the changes to the organisation of the welfare state that took place over the next 18 years of Conservative government. These were characterised by an intention to diminish centralised control, devolve responsibility for running the services to organisations situated closer to the consumer, attempts to use accounting principles to maintain the quality of public services, increased consumer power, and the acceptability of the idea of financial probity.

Attention shifted away from the aims of full employment and equality of access to welfare, that was meant to ensure a safety net for those in need of support, be that housing, education, health or income. However, the impact on welfare state expenditure was mixed during the 1980s and overall it increased, despite Treasury demands.

A more radical solution was required. This was the introduction of general management in the NHS following the report of Roy Griffith (Department of Health and Social Security, 1983). His

Management Inquiry identified the key issue as a lack of a robust decision-making process and insufficient management expertise within the whole of the NHS. As Leathard (2000) noted, the impact has been mixed: improvements in many cases occurred in financial arrangements and in speeding-up decision-making. On the other hand a top-down approach to the running of the NHS has been re-enforced.

These changes were, however, insufficient to deal with the real crisis of increasing expenditure not keeping pace with escalating demands and a lack of commitment by the clinicians to assume management and rationing responsibilities (Alaszewski, 1995). New concepts and organisational principles were then introduced (Department of Health, 1989a; 1989b) that have altered the face of the NHS beyond recognition. The advent of the internal market has resulted in a purchaser-provider split, whereby Health Authorities and GP fundholders (Colin-Thomé, 1996) contracted with health care trusts for specified services for the population within set budgets. One of the major reasons was a need to ensure that the responsibility for expenditure was clearly identified and to leaven clinical freedom with a degree of accountability (Salter, 1998).

Community Care reforms, ideas introduced in the 1989 White Paper (Department of Health, 1989c), were designed to achieve a reduction in the escalating costs of the social security system, especially on the elderly requiring residential care. Real costs have not subsequently diminished - they were transferred to social care budgets, and individuals or their families became the net contributors. As a result of this sharing of financial risks the growth of expenditure has been halted. Before the reforms it was growing at 20 percent per annum.

Comment

What role have these changes played in professionals' lives?

Increased demands are put on the professionals to deal with complex health and social issues presented by an expectant public. A desire to be of service can be compromised by the awareness of financial restrictions and a need to ration human professional resources more effectively. Can IPE contribute in some positive way to dealing with these issues? I return to this in Chapter Four.

In addition, the professions themselves have been under pressure to change.

2.3 CHANGING ROLE AND POWER OF PROFESSIONS - IS PROFESSIONAL AUTONOMY NECESSARY?

One of the features of current societal development has been the diminution of the power of the professions. Three major reasons appear to be responsible - those relating to changes in the relationship between the professions and the public, between the state and the professions, and finally those relating to the professions themselves.

2.3.1 Perspectives on professions and their autonomy

The following discussion needs to be seen in the context of competing views on professions and their need for autonomy. The idealised view of professions is held by many in the professions themselves and represents one of the classic traditions of sociology (Siegrist, 1994). Within that framework, professions are seen to have their vocation based on universal values and a selfless commitment that counterbalances the profit ethos of capitalist society. Thus they need to be independent of state governance. Further, as Durkheim (1957) argued, modern industrial society has become fragmented and lacks in cohesion. There is a need to recreate communities, and the professions have a moral role in reversing the trend towards individualism.

The second and opposing line of analysis takes up Weber's (1978) argument that the professions through social closure are part of a drive towards the concentration of power within monopolies and bureaucratic structures that exclude the disenfranchised population. This stance is very close to the Marxist view of professions (Turner, 1995). Johnson (1972) proposed that the professional 'closed shop' arises from professions assuming the power to define client needs. The feminist perspective (Bryson, 1992) suggests that much of welfare state legalisation and practice discriminates against women, and Ehrenreich and English (1976) argued that the medical profession fulfils the particular role therein of exerting control over the female 'body'. It can be seen from this very brief outline of critics of professional power that the professions need to be controlled more closely and that professional autonomy would need to be curtailed to avoid an abuse of power.

These themes are taken up again in Chapter Eight.

2.3.2 The professions and the public

Whilst the health professions still enjoy an unparalleled public respect, their actions and abilities are put under increasing scrutiny. This is linked to easier public access to medical knowledge and the rise in consumer ideology.

The rise of consumerism in the public sector has been encouraged by the introduction of the Citizen's Charter, followed soon by the Patient's Charter (Parr, 1993). By spelling out the rights of patients as consumers the Government's intent was to put pressure on professionals and providers. Public involvement, as Klein (2001) noted, was just another lever (p 181): 'it was top-down consumerism'.

Nevertheless, the result is the debunking of some of the myths surrounding the knowledge and skills of the professions. Consequently, the professionals have to be prepared to enter into a more equal dialogue with their clients and involve them in decision-making. Another sign of change in the public's respect for the medical profession is the rise in complaints at all levels in the service.

Cruess and Cruess (1997) suggested that the medical profession needs to be aware of the changes in how it is regarded and has to strive continuously to earn the public's trust.

2.3.3 The state and the professions

Increasing control by the state and bureaucracy limits the autonomy of professionals, by challenging traditional professional power that excluded the clients through claiming possession of specialised knowledge. Concerted attempts are being made to show that this knowledge is in fact codifiable and thus capable of being transmitted and measured in a routinised fashion which would allow professions to be monitored by the bureaucracy. This is seen in a move towards competency-based education (see Chapter Four) and rise in the importance of NVQs. Support from the Government for NVQ-based occupational education and qualifications (Brown, 1992) is significant - it allows the growth of a cohort of workers not bound by allegiance to a specific profession, a cohort over whom management has a greater control. The professions, however, argue that their knowledge is not only specialised but needs to be interpreted, and only properly educated and experienced professionals are capable of this (Johnson, 1972).

Taking the idealised view of professions, Shaw (1993) argued that the Conservative government regards the professions and their defence of their constituents' interests as structures inimical to a

rational governance of the state. This is consonant with the ideology of New Right (Alaszewski & Manthorpe, 1990), where monopoly of the professions prevents consumers making informed choices within the market framework. Hence, the government's wish to curtail the autonomy the professions have enjoyed, through their self-regulation, definition of content of work and setting their own professional standards.

In the UK professions are not free to regulate themselves independently. As Moran and Woods (1993) pointed out, the state sanctions such self-regulation. Consequently, autonomy over the determination of issues defining professional freedom, namely entry into the profession, structure of the profession, and remuneration and control of competitive practices, becomes reduced by an increased direct central scrutiny or control.

The adoption of managed market principles seems to shape the development of the relationship between the government and the professions.

Owens and Petch (1995) (p51) commented on the principles behind the 1990 NHS and Community Care reforms:

These were firmly grounded in competitive market philosophy governed by contractual relationships. They were designed to promote private enterprise, limit the scope of the government and control public expenditure...The cumulative effect has been to dismantle professional hierarchies and disperse their power bases.

The authors further noted that other features of NHS reforms (namely the introduction of general management, market principles of devolved budgets, the purchaser-provider split, and the increased involvement of the private and voluntary sectors), prevent rational, professional service planning. They undermine professional ethos and morale, raising doubts in the public eye about professionals' commitment.

Quality assurance

Another feature of the recent changes in the running of the welfare state is the adoption of the notion of quality assurance. This is an inevitable corollary of the move towards increased accountability. The thinking behind it is transparently simple: after all, having devolved budgets and responsibility, how else can central government be assured that the appropriate level of service is being delivered?

What is quality? As Gaster (1995) pointed out, it is an area fraught with contradiction, competing interests and difficulties in finding common ground. Coote (1993) proposed four definitions of quality: traditional, scientific, managerial and consumerist. In the first case the value is implied and it has developed over a period of time. The scientific concept of quality requires the setting of explicit standards, and this is important - this definition comes from the expert group. The managerial perspective on quality is in the ascendance in situations where competition between service providers becomes reality and where contracts define the remit of organisational function. The consumerist definition of quality does not apply that easily to public services as individuals do not have direct purchasing power, which would enable them to shop around.

Without wishing to delve into the full history of the quality movement², it is sufficient to note that interest in it has developed within the UK professional community over the last 30 years. See for example Donabedian (1980) for groundbreaking conceptualisations of quality, or The Royal College of General Practitioners (1985) statement on quality in general practice, with its advocacy of audit. However, power relations have changed since the reforms of 1980s. Clinical audit has become a compulsory activity in trusts since 1989, but not for general practice (Department of Health, 1989 b). And matters have since moved on. Clinical governance, introduced by the Labour Government (NHS Executive, 1999) links explicitly and in a structured way clinical performance (as assessed by audit) according to clinical guidelines, with assessment of the needs of the service and with professional education. While the monitoring is done by the professionals, the reporting and accountability is to the manager group - locally and nationally.

This change in emphasis, the move towards the management-dominated agenda, is characteristic of the neo-liberal philosophy, that foregrounds efficiency, measurable output and value for money (Lane, 1995; Farnham & Horton, 1999).

Inevitably quality assurance will surface in all aspects of my research - both in health and social care arenas, as well as in education (see especially Chapter Eight for critical analysis of these emergent themes).

² See Irvine and Donaldson (1993) for more detailed history

2.3.4 Changes in the professions

As Turner (1995) noted, the development of the professions themselves leads to fragmentation as professional sub-groups claim autonomy from the main body and wish to acquire the status of new professions.

This trend has been most evident in the nursing profession. The emergence of nurse practitioners (Bryar, 1994) or specialised nurses such as continence advisers (Rhodes, 1993) have highlighted the fragility of professional boundaries. Similarly, practice nurses and new care and assessment managers in social services encroach on the territory of community nurses (Hibble, 1995; Owens & Petch, 1995).

A number of developments in community nursing has been recorded over the years. While some of these may appear to trespass on the GPs' role (such as district nurses taking on an enhanced role in the care of diabetics or the terminally ill in the community), frequently this has been accepted gratefully as such delegation allows GPs to concentrate on other tasks (Boddy, 1969).

Midwives have succeeded in shifting the focus of the management of pregnancy from a doctor-led model to a midwife- or, as they put it, woman-centred model (Department of Health, 1993). In part this move has been in response to the women's movement's views opposing the medicalisation of what may be regarded as a normal, physiological process. In some cases they offer 24 hour cover throughout the pregnancy, thus taking on another characteristic of an independent professional (McCourt & Page, 1996).

Further impetus for greater professional recognition flows from changes to the training of nurses at basic and post-basic level as this moved to institutions of Higher Education. This offered greater academic respectability through the acquisition of diplomas and an easier path towards a higher degree (UKCC, 1986). A greater proportion of time is given to acquiring theoretical knowledge as this provides not only a better theoretical foundation for professional work, but also legitimises the nursing profession as having its own discrete high status knowledge.

2.3.5 Comment

What impact are the above-mentioned changes having on teamworking and on the role of IPE? Two contradictory outcomes are possible. Firstly, a challenge to traditional professional boundaries and remit of power and hitherto accepted respect, offers an opportunity for the professions to reassess

their interaction and to search for a better means of working together in what might appear to be a hostile environment. Interprofessional education can find a distinct role in such an enterprise by fostering a frank interchange and allowing new insights to emerge. This would allow the forging of different ways of working together, that would reduce the threat to professional independence and unnecessary conflict.

Secondly, there is a more pessimistic outcome. The threat to one's professional certainty might provoke a retrenchment, a territorial defence and unwillingness to face the changing reality. A push for closer interprofessional collaboration and shared education under these conditions could be seen to pose additional threats to an already fragile professional definition, especially by doctors whose role is being questioned.

2.4 CHANGES IN THE ORGANISATION OF CARE

In the last thirty years there have been continuous changes in the organisation of primary care services. What are these changes and what implications do they have for teamwork?

Changes in primary care

The most noticeable changes have been in the alteration of roles, and in the workload of the caring professions. The relationships between professionals had to change.

Primary health care professionals have assumed an increasingly important role in the provision and organisation of health care in recent years. A substantial impact on the workload in primary care has been the increased involvement of GPs in the care of those patients who would previously have been the exclusive province of a hospital-based staff. Establishment of health centres in the 1960s provided an opportunity for interprofessional co-operation and a stimulus for an extension of tasks performed in primary care. Conditions like hypertension, diabetes, angina, and peptic ulcer can be managed competently, as direct access to diagnostic facilities enables a prompt diagnosis and follow-up. Direct access to investigations reduces pressure on outpatient and inpatient workload (Hobday & Price, 1989).

General practice workload has been increasing steadily even before the introduction of the new GP contract (Department of Health, 1989a), with GPs spending more time with patients and undertaking an increasing range of tasks. The new contract has increased the workload of GPs further (Hannay, Usherwood & Platts, 1992). Practice nurse workload has followed a similar

pattern (Hibble, 1995). Earlier discharge into the community puts an additional burden on all the primary care professionals.

The major reconfiguration of the NHS in 1990 (Department of Health, 1989a; 1989b) extended the range of tasks and responsibilities of GPs and their teams. They now had to provide a more comprehensive care through more formalised health promotion activities and better organised approaches to chronic disease management. This was supported to an extent by an additional remuneration (Department of Health, 1992a).

The introduction in 1993 of Community Care legislation (Developing Managers for Community Care, 1995) helped to alter the balance of patient care between hospital and community settings (Hennessy & Tomlinson, 1994). It encouraged targeted expenditure by Social Services to prevent admissions of highly dependent individuals to hospitals and residential homes (Hennessy & Tomlinson, 1994). The role of social workers has changed substantially through the introduction of the purchaser-provider split in Social Services and different prioritisation of cases. Social work departments are now less involved in the direct provision of services as they have taken on the case management role. The impact of these changes on primary health care professionals is two-fold: more people are now cared for in the community and individuals not assessed as high priority by Social Services have to rely on support from GPs and community nursing staff.

2.5 POLICY CONTEXT FOR TEAMWORK

Policy development relevant to interprofessional collaboration comes from both Central Government and the professional organisations themselves. Central Government policies and the forces shaping them are outlined in general and as they pertain to primary care. How well are these intentions translated into action?

2.5.1 Government policies

Health and Community Care

The complexity of collaboration in health and welfare is illustrated by the plethora of policy documents and reports highlighting the problems in, and solutions to, fragmented service provision (Royal Commission on the National Health Service, 1979; Department of Health and Social Security, 1981a, 1981b; Department of Health, 1989c; Audit Commission, 1992). A number of these documents exhort the different agencies and sectors to co-operate for the sake of clients.

Recently more relevant structured means, designed to implement these good intentions, have been proposed. Marginalised areas such as mental handicap, mental illness (Department of Health, 1990a), child abuse (Home Office et al., 1991) or care of highly dependent people in the community (Department of Health, 1989c; 1995) have received attention, and collaborative procedures and structures have been established to help the planning and delivery of services. The NHS Management Executive supported the development of networking to facilitate the introduction of Community Care (Developing Managers for Community Care, 1994a). This has helped the growth of a more co-ordinated planning of services and collaboration across agencies, and has facilitated teamworking among the relevant professionals. Part of the drive for an improved collaboration has been the support for interprofessional learning activities.

Primary care

Primary care has also been the subject of specific policy initiatives. In 1974 the primary health care team emerged as an identifiable term in the parlance of the DHSS (Department of Health and Social Security, 1974a). A few years later (Department of Health and Social Security, 1981b) the primary care team became the subject of a separate report that contained a groundbreaking suggestion linking the functioning of these teams with a shared education.

In the last decade the pace of change has accelerated with primary care assuming an increasingly important role in the thinking of policy makers. The NHS reorganisation in the 1990s shifted the emphasis of care into the primary care setting (Department of Health, 1989a; 1989b) and resulted in expanded primary care teams based in GP surgeries. Introduction of the internal market has not facilitated collaboration between GP teams and community services, as the latter have had to concentrate on fulfilling contracts. In addition, GP fundholding shifted power into fundholders hands, thus recreating the master-servant relationship between the GPs and community staff.

The Health of the Nation strategy document (Department of Health, 1992a) encouraged the formation of alliances of key players (including the NHS, Health Education Authority, employers, education and voluntary organisations) to co-ordinate an approach to health promotion in the community. Despite considerable effort and some innovative examples of alliances, the outcomes are difficult to quantify (Gaskin & Vincent, 1996). This, of course, is in the nature of health promotion, as the alteration of health seeking behaviour requires time and a multimodal approach.

A number of changes to the function of primary care teams were proposed by the last administration in three White Papers (Department of Health, 1996a; 1996b; 1996c) that would have

provided opportunities for enhanced teamwork. These included the provision of more services by community-based teams through practice-based contracts, and additional funding for the transfer of services from secondary to primary care settings.

2.5.2 Policies of professional organisations

Professional organisations represent the interests of their constituent professional groups. Their primary task is to ensure that professional independence is maintained and the standing of their members is enhanced. To achieve this task a two-fold approach characterises the action of professional bodies. First, they need to be seen to promote high standards of professional conduct to avoid an imposition of central control. Second, they need to respond flexibly to the changing social, economic and political environment in providing guidance to their members, so that working practices, attitudes and education keeps pace with these developments (Watkins, Drury & Bray, 1996).

What role do these bodies play in promoting and developing primary care teams? Overall, they recognise problems resulting from increasing fragmentation in health care and all of them show a commitment to the ideal of interprofessional working.

Policy documents, at least, bear witness to a positive regard for interprofessional work. Regular reference to teamworking is present in these documents from the early 1970's (British Medical Association, 1970; Royal College of General Practitioners, 1970; Royal College of General Practitioners & CETHV, 1973; Panel of Assessors for District Nurse Training, 1976) to the present day (Damant, 1990; CCETSW, 1991; UKCC, 1991; GMC, 1993; Royal College of General Practitioners, 1996). Professional bodies try to promote an appreciation and implementation of teamwork through encouraging education and training institutions to pay attention to these issues in the design of their courses, both at undergraduate and postgraduate levels. There is evidence of goodwill, as a number of professional organisations in the health and social care field have collaborated to produce statements of intent (Baraclough et al., 1983) or established collaborative forums, such as the Alliance for Primary Care. As the link between effective teamworking and team education has become clear, support for IPE has strengthened. A more detailed treatment of the developments of these ideas is in Chapter Four.

2.5.3 The impact on professionals' work

The interrelated factors outlined above, contribute to the changing profile of the work of health and social care professionals. Changes in health care policies and economic issues have resulted in pressures to deliver more services within restricted budgetary considerations, while continuing to maintain high quality (Coote, 1993). Workload has increased faster than the rate of growth in the ranks of the caring professions.

The importation of significant market-orientated concepts and practices (Flynn, 1993), that challenge traditional professional certainties, values and priorities, have been accompanied by increased stress (Sutherland & Cooper, 1992; Caplan, 1994; Hadley & Clough, 1996) and the lowering of morale within the professional groups (Royal College of General Practitioners, 1994a; Anon, 1995a; Seccombe & Smith, 1996). Additional pressure comes from attacks on the independence and self-regulation of the caring professions, and from the introduction of a skill-based workforce that is not socialised into a professional framework (Beachey, 1988; Barr, 1994).

2.6 SUMMARY

I have described in some detail in this chapter the major factors determining the changes in professional education. I have argued that outlining the genesis of these forces is essential to an understanding of the current professional and educational landscape.

The welfare state in the 1990s looks different compared to the previous 40 years. Increased demands through a slowing down of the economy, increased unemployment, and demographic changes have not been matched by an adequate rise in the state's income. Health care is becoming more expensive with more effective, but more costly, technologies being available. As a consequence successive governments, regardless of their ideological orientation, have introduced reforms with a market-based design.

Within the NHS, primary care has emerged as a pivotal structure to achieve the necessary efficiencies in the running of services. At the same time there have been considerable shifts in the perception of the professions by the public and the Government, and parallel changes in the relationships between the professions. The most notable one has been the increased status of the nursing profession. We have also seen a rise of general management as an important part of the governance of these services. The professions appear to be under siege.

I have outlined, albeit briefly, the key policies of both the government and the professional organisations that lie behind the changes in the running of health and social services organisations and which determine the need for teamwork and interprofessional education.

3 CHAPTER THREE - BACKGROUND: REVIEW OF INTERPROFESSIONAL TEAMWORK

3.1 INTRODUCTION

Why has teamwork assumed such a prominent place in the thinking of health care planners and managers? A modern welfare state, as described in the previous chapter, has developed its institutions of personal care in a fragmented way while trying, ambitiously, to address the complex needs of service users. Collaboration is seen as a way of bridging these gaps. A detailed description of the policies supporting team development was presented in the previous chapter. Interprofessional education, as will be argued later, has grown to support the team ethos and efficiency.

This chapter will focus on those aspects of teamwork that are amenable to an interprofessional educational intervention. Other issues, important to understanding teamwork in its complexity but not of an immediate relevance to the discussion in this thesis, are to be found in Appendix One. There a brief description of such issues as the origins of teamwork, leadership, or the evidence for its effectiveness will be given.

Four sections address in turn the background issues, structural aspects (including membership issues), the function of teams (including questions of communication), and finally an analysis of team tasks.

3.2 BACKGROUND

This section attempts to answer two questions. Firstly, what are the tensions between the perceived advantages and disadvantages of teamwork? Secondly, is it possible to clarify the terms used in this field?

3.2.1 The value of teamworking: advantages and disadvantages of interprofessional work

Interest in teamwork and its potential contribution to the improvement of patient care needs to be balanced by considering the pitfalls of interprofessional collaboration both for clients and team members. Uncritical acceptance of arguments for interprofessional collaboration leading to better quality and cost-effectiveness of care may have obscured the need to analyse the advantages and disadvantages of this ideal.

The arguments for and against teamwork are presented side by side for ease of comparison and are divided into three areas - those concerning the organisations, the users of services and the team members. See Table 3.1.

ADVANTAGES OF TEAMWORK	DISADVANTAGES OF TEAMWORK
For the care organisation	For the care organisation
Efficient teams can overcome the fragmentation of care and compensate for the inability of a single profession to cope with complex tasks.	<p>For a team to function well, it needs to communicate effectively. This requires an investment of time and is not easy to achieve in large collaborative structures.</p> <p>Fear of confrontation or of challenging accepted patterns of behaviour can become counterproductive (Hackman, 1992). The team will stop developing.</p>
Client need	Potential problems for clients
Clients can benefit from team members sharing their expertise and co-ordinating their actions. In this way, a duplication of effort or misconceptions about task fulfilment can be avoided (Webb & Hobdell, 1980). A more comprehensive or holistic care can be provided in co-ordinated teams.	A collusive team, that sees effective co-ordination as an end in itself, can disempower clients, especially the vulnerable elderly or mentally ill (Williamson, 1995). Within the team accountability can become diffuse. Clients are faced with an amorphous organisation which presents as a united front, particularly in cases when a professional is seen to act on behalf of the team (Barnard, 1987). Patients or their carers may find it difficult to challenge the team acting in a concerted way.

ADVANTAGES OF TEAMWORK	DISADVANTAGES OF TEAMWORK
Team member perspective	Team member perspective
Working in teams can provide an opportunity for personal and professional growth (Hackman, 1992). Individuals can learn from each other, share their frustrations and feel fulfilled by a feeling of belonging to well-functioning unit.	Teams can be a source of stress, as professional identities will be challenged and the traditional sense of belonging to a well defined professional group questioned (Laungani & Williams, 1997).
An open debate about the division of tasks and appropriate use of skills can firm up each professional's sense of pride and usefulness to the team effort.	A wish to be accepted may force a conformity with the prevailing team norms, thus countermanding the growth of individuals and teams themselves.
	A pressure to use resources effectively may present teams with uncomfortable dilemmas. If teams do not achieve allocated performance targets, they can be blamed for inadequate allocation of financial and human resources.

Table 3.1 Advantages and disadvantages of teamwork

Powerful arguments can be marshalled for and against teamwork. These tensions are not resolved easily. Debate needs to continue at policy level and at the professional coal-face, so as to avoid the pitfalls in, and enhance the benefits of professional collaboration. An additional perspective from the Foucauldian angle is outlined in Chapter Seven.

I will argue later that IPE plays a vital role in clarifying these issues for the professionals themselves.

Definitions

A clarification of some key terms used throughout this work is required: namely, what is a team, and more specifically a team in primary care, and the meaning of interprofessional collaboration.

Teams and other collaborative structures

Two principal characteristics differentiate teams from other groups (Pritchard, Low & Whalen, 1984; Adair, 1987; Larson & Lafasto, 1989). These are:

- a) the sharing of aims and,
- b) the co-ordination of activities through the sharing of resources, including knowledge and skills.

Teams share with groups a number of characteristics, such as presence of a group culture, the influence of group dynamics on their function, and issues of leadership. However, the key difference is in the aims. While groups are constituted to work together for the exclusive benefit of their members, individuals in teams subscribe to aims requiring co-operation to produce agreed outcomes, benefiting others as well as themselves. To illustrate - a therapeutic group will meet regularly to facilitate the exploration of individuals' problems, but the focus of its effort is internal to the group. On the other hand, a team of family therapists will co-operate to help a family to gain insight into their conflicts, thus enabling them to function more effectively. The agreed aim of the therapeutic team is outside its own needs.

The principal attention in this work is on teams, their function and characteristics. Also, teams need to be defined in terms of their membership and interest here is on interprofessional teams.

Teams in primary care

In primary care two different concepts of the team have emerged: the primary medical team and the primary health care team. The first refers to a team based in general practice premises. The core team comprises the four main primary care professions (GP, PN, HV and DN) and the extended team includes the other health workers (Royal College of General Practitioners, 1996). The second description represents links between health professionals working in the community and does not necessarily include the GP. This perspective reflects a dichotomy between a medical model that advocates an individual-centred care and the wider population-based approach to health care (Marks, 1989; Gregson, Cartlidge & Bond, 1991).

Interprofessional collaboration

Teamwork as a concept is used in this work to denote collaborative working between different professionals in health and social care. As Leathard (1994) helpfully pointed out there are a large number of terms attempting to describe interprofessional work. She categorised these terms (p5) into three groups:

- **concept-based terms**, such as inter-disciplinary or multi-disciplinary;
- **process-based terms**, such as joint planning, joint working, joint management or teamwork, co-operation, collaborative working;
- **and agency-based expressions** such as inter-agency, inter-sectoral work.

The processes in teams are examined closely in this work and terms from the second group are used predominantly. I use some of these terms - namely teamwork, co-operation and collaboration - interchangeably, whilst acknowledging that teamwork as a specific descriptive should denote close collaborative arrangement, whereby there is sharing not only of aims, objectives and purposes, but also of resources such as skills, premises and finances. In addition, teamwork can be characterised by a close integration of communication systems and of activities, such as planning and delivery of care.

Teamwork at its best represents a form of collaboration where individuals have a greater allegiance to the work of the team than to their professional group or their line manager. While ideally professionals would feel able to work with these reference points without being questioned about their loyalty, it is difficult at times to reconcile the tensions inherent in such situations.

Collaboration on the other hand is a much looser term, it denotes a degree of working together and it can be applied both to differing settings from strategic to operational, and to working together between different agencies or sectors. Each of these modalities has an impact on patient or client care, but the major emphasis in this work is on interprofessional work at the professional-client interface. Collaboration on a strategic level, between agencies, is concerned with the planning and development of policies. This, as will be seen later, is important when recommendations for reconfiguring the structure of management of the caring agencies needs to be considered, in the light of difficulties encountered in implementing the policies for teamwork or IPE.

Comment

Teamwork is here to stay. The intentions behind its promotion are laudable, but implementing it is not easy. Similarly, an enthusiasm for teamworking needs to be counterbalanced by a critical awareness of its costs to the organisations, individual professionals and service users.

3.3 STRUCTURAL ASPECTS OF TEAMWORK

A number of problems pertaining to team membership elicit opportunities for an educational intervention. There are other characteristics affecting the functioning of a team, such as how it is integrated within a larger organisation, or its size, but these are for management to address rather than individual team members.

3.3.1 Membership issues

How well a team functions depends on the characteristics of its membership, and the differences in professional backgrounds, power, status and given responsibilities.

Professional issues

Many obstacles to effective teamworking are due to the development of professionals (Scott Wright, 1976) themselves and to their differing educational backgrounds (Bligh, 1979; Freidson, 1983; Hogg & Abrams, 1988). A difference in the level of educational attainment between the two principal professional groups in health care is longstanding, and is linked to their differing remit. Doctors will complete a university degree and function as independent professionals. Relatively few nurses will end up with a nursing degree and only a small proportion are given the freedom to act with complete professional freedom.

Bligh (1979) suggested that as a result of the socialisation process into a closed professional group, young professionals acquire a tribal identity with its own status, behaviours, language and stereotypical values and judgments. (See also discussion on team culture in Appendix One). Firm professional identities may prevent collaboration between professionals (Lewis & Resnik, 1966; Damant, 1991; Sparkes, 1992), as they may find it difficult to acknowledge the validity of differing perspectives on care. While nurses may at times feel too intimidated to contradict doctors, doctors themselves may find it difficult to let go of their power and status.

Status differentiation

Social differences between the professions, or social stratification, accounts for a number of the obstacles to teamworking. We do not live in an egalitarian society, and social differences are embedded in its fabric. Inherited positions account for less than what one is able to achieve through one's own efforts - meritocracy is a feature of capitalist society. Social stratification can be described in terms of class, status and power (McIntosh & Dingwall, 1978; Bond & Bond, 1986).

Class relates to the differences in income, wealth and education between doctors and most other health workers. Even though there is some controversy in using this category to describe the differences between social groups, a classification such as the Registrar's General is useful for an analysis of social movements and morbidity trends. Interest here, however, is on the differences between the care professionals. Doctors belong to Class I, the professional class, nurses to Class II, the managerial one, while secretaries are classified in Class III or the skilled manual class.

Status more than many other issues causes tensions. Status is a social construct, and it denotes the social respect associated with a particular occupational group. Changes in social status are possible. A good example is the lowering of the status of teachers in our society over the last 50 years. It could be argued that the given status of the three main occupational groups at the centre of concern here, namely doctors, nurses and social workers, has not altered substantially in the same period, despite a questioning of the power of doctors.

Power issues

The issue of power in interprofessional contact is important. The tensions inherent in misperceptions about the origin of the power can undermine the will to work together. Two perspectives on understanding aspects of power are offered, followed by an observation about changes to the distribution of power among the professional groups in recent years.

Armitage (1983) argued that doctors in the primary care setting have greater power in all five of its manifestations ³ (as described by French and Raven (1959)). These aspects are: reward, coercive, legitimate, expert and referent power.

³ The conceptualisation of power used here differs from that used later on in the thesis for analysis of relationships between the stakeholders. Attention here is more on the sociological analysis, while in the discussion in Chapter Seven and Eight is more on the policy arena.

The reward element refers not only to the financial aspects of a particular occupation, but also to a personal recognition or favours that a specific professional can dispense. The power of the manager lies not only in her ability to allocate cash equivalent rewards, such as access to courses, but also in an ability to give an individual nurse preferential treatment in terms of preferring her account in disputes between colleagues.

The coercive element of power relates to the fear of losing position or advancement. For example, a junior doctor may be reluctant to challenge the consultant's views as it would endanger getting a positive reference.

The legitimate aspect of power, as described above, is due to the socially accepted position or status of the professional.

The expert element of power is the only one that relates directly to professional expertise. If power was determined by this element alone, interprofessional relationships would be more equal. Within each team an individual with a specific expertise would be able to lead on that aspect, with other members giving the necessary respect to enable them to function easily.

The last characteristic of power is its referent aspect. It is closely linked with charisma and the need of a subordinate to identify with a powerful, important person. It is still possible to hear community nurse colleagues talking about their location of work in terms of the senior partner.

The second perspective, based on the contingency approach (Luthans, 1989), is relevant to an understanding of the role of power in primary care teams. It offers three elements characterising the power relationship between the team members: compliance, identification and internalisation.

The compliance with a doctor's wishes depends on a real and perceived power to reward or punish and the degree of surveillance in place - thus a practice nurse will be more compliant than a district nurse.

Similarly, identification with a team will be influenced by structural and functional proximity and a wish to participate in teamwork.

Another, more influential factor - internalisation - comprises legitimacy, expertise and credibility. While, as mentioned above, other professional groups are trying to define their own territory,

doctors' power is still seen as legitimate. Internalising these features of power as a given is a social phenomenon that may prevent the questioning of a traditional form of interprofessional behaviour.

The situation is not static. The struggle for supremacy and control between professional groups is based on a perceived or given legitimate power. The medical profession is a prime example of an occupational group claiming its primacy on the basis of clinical responsibility (see later). This perception encourages a medical model of care to be translated into the structure of care within which other professions are seen as subservient.

Note, however, how the NHS reforms of the 1990s brought about the redistribution of power (Hiscock & Pearson, 1996) - from the secondary to the primary sector, from hospitals to purchasers, from professionals to managers. As a result of fundholding GPs' ability to purchase community nursing services, power relations changed. Nurses employed by these practices did not feel they acted as independent professionals. Their allegiance shifted towards new employers and their support networks were threatened.

Gender issues

Gender issues permeate interprofessional work. They are reflected in the constitution of professions, in interpersonal relationships and in teamwork itself.

Traditionally medicine was a male-dominated profession. Nowadays, up to 50% of medical students are females and a similar proportion enters GP vocational training. However, the profession is still oriented towards full-time work, and a large proportion of female GPs belong to so-called 'lost tribes' - working as locums, as retained doctors or not working at all during the early stages of child-rearing. The result is that only about 1/3 of GPs are females. Other professions, such as nurses, PAMs and social workers, have a predominantly female membership. This difference could be traced to societal roles ascribed to women, the roles of caring, helping physically and emotionally to alleviate suffering and of maintaining the family unit (Williams, 1989). These values and the roles that a patriarchal society encourages women to take up are located in the profile of work of these 'para-professions' (Gamarnikow, 1978; Huntington, 1981).

Traditionally, the gender differences linked the division of the roles with authority. Thus nurses were expected to follow physicians' commands. This has changed somewhat following the Salmon Report (Ministry of Health, 1966). Nursing structure became independent of medical hierarchy, and, at least overtly, nurses appear to run a parallel functional organisation in hospital and in the

community. The introduction of an independent managerial structure to nursing has helped to create a hierarchical, bureaucratic organisation that provided an opportunity for nurses to have careers. While this has encouraged men to join the profession in increasing numbers, it is notable that they are represented disproportionately in the management positions (Bond & Bond, 1986).

It is clear that these gender issues impact on teamwork. Of primary importance is the authority and power of different professional groups. The status and power that doctors claim or are accorded by society are reinforced by the gender differences (Abbott & Wallace, 1998). For example in a primary care team, with the exception of nurse-led Primary Medical Services pilots, it is unlikely that leadership of the team will be vested in one of the non-medical staff, thus emphasising the difference in power between male and female members of the team.

Role issues

Perhaps the most contested area in interprofessional relationships relates to team roles. Differences in understanding of role definition and threats to role stability require close attention by team members and those responsible for them, to ensure they function smoothly.

Brown (1988) suggested that a need for role adoption or allocation is threefold. First, a division of the team's work helps to organise the work more efficiently. Second, it provides stability for team members and allows them to work with each other in a predictable way, knowing what to expect from others. Lastly, this differentiation helps to firm up an individual's identity, to locate the self in the social world with clearly designated tasks and to acquire a value or respect associated with a specific role.

Problems can arise if there is lack of clarity about given or assumed roles in the team, and such tensions will be compounded if changes in roles are not negotiated in a constructive way.

Adair (1987) listed five types of role problems (p36): conflict, incompatibility, ambiguity, role overload and role underload. Only the first three are relevant to interprofessional work.

- Role conflict will occur when the demands of two roles an individual plays, clash. For example: tension between the time demands of being a doctor and being a teacher or a trainer.

- Role incompatibility arises with different interpretations and expectations of a given role, as can be the case of a nurse being asked to bath the patient by the GP.
- Role ambiguity can be seen when a team is joined by a professional whose remit and tasks are unclear. This could apply, for example, to a social worker attached to a primary care team, who would need to define the type of work suitable for a social work intervention, and negotiate it with the rest of the team.

Øvretveit (1987) explored the need for clarifying team members' roles and competencies to avoid conflict. He described four types of competencies: profession-specific, overlapping, common and non-profession-specific. Further analysis of the concept of competencies can be found in Chapter Four. For the purpose of this discussion, competence will refer to a learned ability that has been assessed and codified.

- Profession-specific competencies cover specific roles and acquired skills such as prescribing, which at present is the remit of physicians only.
- Overlapping competencies occur in teams when there is similar learning during professional formation. An example of this is health promotion and education, where GPs, PNs and HVs share the same competencies, even if to a differing degree.
- Common competencies arise in the case where professionals have learned the same skills to the same degree, such as counselling.
- The last category of competencies, the non-profession-specific, refers to a situation where the knowledge and skills acquired, such as acupuncture, are in addition to core professional skills.

The distinction between common and non-profession-specific competencies hides within it an assumption that an acupuncturist is not a member of an occupational group with its own distinct rules of conduct and registration procedures. Overlapping and common competencies require a clear agreement on task division.

The way forward?

A considerable potential for confusion, misunderstanding and disharmony exists. It is thus incumbent on team members to face these issues, clarify their respective roles, negotiate boundaries of acceptable role overlap and be prepared to be flexible as the roles develop.

Evidence from research ought to strengthen the call for a structured management or educational approach to solve these problems. Research in the health service has shown a link between clarity of roles and collaboration (Draper et al., 1984; Gregson, Carlidge & Bond, 1991).

Another element in interprofessional work needs to be addressed at this juncture, as it interacts closely with issues of roles, power and status. It concerns the assumption or allocation of responsibilities in interprofessional teams.

Responsibilities in teams

Responsibilities in teams have been explored by Furnell et al (1987) (p15) :

By their nature, MDCTs (*multi-disciplinary clinical teams*) are likely to raise issues over professional responsibilities and boundaries.

The authors emphasise the need to consider and to differentiate between certain characteristics of responsibility, namely legal, professional, prime and contractual. **Legal** responsibility refers to the legal underpinning of professional action, such as a duty of care. It links the potential outcome of a professional's action and the standards that need to be maintained in order that such an action is not damaging. The implication in interprofessional teamwork is that 'no professional can be held responsible for another professional's action except in part by negligent delegation or referral' (Furnell, Flett & Clark, 1987) (p16). A legal framework has yet to be developed to cope with the diffusion of responsibility that is inevitable with teamwork (Montgomery, 1989).

Other characterisations of responsibility provide a lesser degree of clarity. **Professional** responsibility takes on a wider meaning beyond the legal one, incorporating sets of standards underpinning professional action that have been agreed by the professional bodies.

Prime responsibility according to Furnell et al (1987) refers to the co-ordinating authority in casework. This is essential to clarify in teams. The leader of the team does not undertake this type of responsibility. Her role will be co-ordinating the activity of the team, but in a specific case, an

individual - a keyworker - needs to be identified who will hold the legal responsibility for the management of the case.

Furnell et al (1987) conclude that (p16):

claims of "primacy" (*automatic assumption of prime responsibility*) in an MDCT setting from any source, appear untenable and incompatible with both the Tort of Negligence and also the varied nature of modern health care which crosses many professional boundaries.

An individual professional has responsibility to the individual patient to provide competent care, whilst **contractual** responsibility denotes the relationship to the employer. In considering **responsibility to the team**, it is essential to clarify the roles, division of tasks and relationships between team members to avoid conflict between these differing aspects of responsibilities that can impair patient care and team function.

The implication of differences in the structure of teams

Primary care teams are heterogeneous organisations. Their members differ on various indices as noted above - their social and educational backgrounds, their range of skills, age and status. In highly differentiated teams two apparently contradictory outcomes can be anticipated in regards to their stability and creativity. Teams are likely to be less stable, and to have a higher turnover if the differences between members are greater (Jackson et al., 1991). This might explain the relative stability of GP partnerships, as they share many of the same features. On the other hand, the differences between members are likely to encourage productivity, if conflicts are well managed, converted into creative tension, and leadership is supportive (Schachter et al., 1951).

3.4 TEAM FUNCTIONING

The internal functioning of a team is determined by the external context within which it operates, the pressures from other organisations it works within or collaborates with and by the needs of its client population. The profile of its members and differences between them impact on their relationship and ability to work together. What are the principal team processes? How do these processes and especially collaboration between team members impact on their client groups?

Group processes

Teams exhibit all the processes characteristic of group life. Of interest here are group maintenance processes with a particular focus on communication in teams and on the process of collaboration. Learning in teams, another important process, is addressed more extensively in the next chapter. It is sufficient to observe here that the concept of a learning organisation (Davies & Nutley, 2000) is relevant, as it allows team learning to transform into a dynamic process, whereby a team adopts a flexible approach to its work and to its changing environment.

Group maintenance functions

Individual team members take on group maintenance and task-orientated roles (see Appendix One, section 1.2), that enable the actual tasks of the team to be performed. An awareness of the importance of these functions is shown in the considerable investment in teambuilding activities seen in primary care in recent years. While, as is shown later, evidence for the effectiveness of such efforts is mixed, the intention is clear. Functional improvement will allow interprofessional teams, it is thought, to take on an increasing range of care tasks.

3.4.1 Communication in teams

Communication between team members is the essential building block of a team's cohesiveness and collaboration. The heartfelt cry of all those keen on effective teamworking - 'If only we could improve interprofessional communication!' - reflects the perceived obstacles to success and sets the agenda for action.

The size of the team determines ease of communication. While this is relatively easy in smaller teams, for larger teams to maintain information links with any degree of success, formal structures need to be put in place.

The process of communication, beside being determined by external structural attributes, such as available time and means of communication, is influenced by the internal landscape of participants. Jaques (1991) suggested that personal values, beliefs and attitudes impact on the congruence between the overt and covert purpose of the communication. A dissonance between intended and unintended transmission will be manifest by non-verbal signals or by ignoring conversational conventions. For example, a GP who professes a belief in good interprofessional contact, will signal his opposite values by turning away from a nurse while talking to her, or by not responding

to the question posed by her. The receiver of the message similarly may distort the content of message by hearing what is congruent with his expectations. This might occur in the case of a patient who hears the receptionist refusing an appointment, rather than listening to the alternatives offered.

Communication thus plays a pivotal role in the life of a team. Attention needs to be paid to it by members and leaders of a team to avoid a mismatch between the perceptions, interpretations and purposes of information exchanges. It is simply not enough to acquire communication skills, or to be able to interpret the behaviours of others.

3.4.2 Collaboration in teams

Collaboration subsumes the basic features of teamworking i.e. sharing aims and resources, and communication. As a characteristic of team's life it is easier to analyse than other aspects of team function (Gregson, Cartlidge, & Bond 1991). In addition, as was pointed out earlier, it is tempting to identify a lack of collaboration as a root cause for inadequacies in the delivery of care.

It is necessary to question an implied assumption that for an interprofessional team to function successfully there must be a total integration of the work of team members. In a number of cases uni-professional effort is adequate to achieve desired results.

Casey (1985) in his discussion of teamwork argued for a match between the **tasks and the form of interaction**. Thus for 'simple puzzles' there is no need to share workload, while 'complex puzzles' require some degree of co-operation. At the other extreme, for problems that evoke 'shared uncertainty' collaboration is essential and very close integration of individual effort is needed. Skills required for differing degrees of sharing correspondingly range from, at one end of the spectrum, polite social skills, through negotiating and co-operative skills to, at the other end of the spectrum, the highest interpersonal and group skills.

Interprofessional education is seen as a way of improving teamwork. Intervention studies, e.g. Mazur et al. (1979), Brown (1993a) and Hutt (1994), demonstrated the impact of interprofessional education (IPE) on teamwork (see Chapter Four for more detail).

The research evidence, presented in detail in Appendix One (section 1.3.1) supports the importance of factors explored so far. Successful collaboration is dependent on its external context, such as support from management and co-operation with other agencies. Structural elements also play a

crucial role - closer physical arrangements aid working together. Team members characteristics and interaction with each other contribute to success or failure in achieving a common goal.

3.5 WORK OF THE TEAMS

The purpose of a primary care team's establishment and development is its place in delivering care to its client group. What are the key activities that a team is involved in to achieve this primary task? Is it possible to discern with any degree of certainty a relationship between the various aspects of a team's structure, functioning and its work?

3.5.1 Team tasks and activities

A team's tasks are linked to its output as an organisational entity. Three principal activities can be discerned - policy decision-making, planning and care delivery. The first two are precursors of the third activity.

Policy decision-making

Within health care teams, policy decisions have to be taken about issues that directly affect their work. Some of these reflect national or health authorities' (HA) policies, and teams have to decide if they wish to implement innovations such as participation in primary care pilots. Other policy decisions relate to a new direction the team members would like their teams to take, such as participating in research or teaching. As Øvretveit (1987) pointed out, a more specific, so called 'operational' policy-making needs to include clarification of roles, decisions on procedures and systems to be used by the teams, and agreement on staff development and training. In a democratic team all the members would have an equal vote. This, however, is rare and reflects the inequality of power and status discussed above.

Planning in health care teams

Health care teams are involved to a varying degree in planning their activities. Ideally, such planning should be based on clear and agreed policies. The most important determinants of a need to plan at the level of the primary care team are the complexity of the task and the degree of responsibility devolved to the team.

A team with a greater degree of independence, such as a core team in general practice, will be able to take on the responsibility for organising a more comprehensive pattern of care, that will include complex tasks such as an immunisation programme or running chronic disease clinics (e.g. diabetes and asthma). These tasks require the co-operation of diverse team members, and in an efficient setting systematic planning and review of progress will take place. Team members' commitment to co-operative tasks can be enhanced by their ability to influence the planning and implementing of the procedures designed to execute such tasks. For example, receptionists who help in designing a system for a diabetic clinic that is intended to optimise patient flow, will feel committed to ensuring the success of the project.

Agreeing on aims and objectives

A cohesive team is defined by the ability to agree on common aims and objectives for its activities. Difficulties in achieving democratic consensus are cited frequently as a cause of malfunction in teams (Pearson & Spencer, 1997; West & Poulton, 1997). A shared vision can energise a team to work better and derive satisfaction from belonging to a unit with a clear commitment to provide high quality care.

Potential problems in policy-making and planning in teams

Such problems can occur by virtue of the differences in professional background, different lines of accountability and varied perceptions of tasks or priorities. If, for example, practice nurses suggest the introduction of new health promotion activities, their employers, the GPs, might block progress in decision-making if they feel that nurses would be distracted from performing other routine tasks.

Complexity of group interactions can contribute to difficulties teams experience in planning their work and dividing their tasks. If a member of a team does not feel valued, unconscious sabotage of decision-making and task execution can occur.

3.5.2 Outcome of teamwork activities

A full review of the outcomes of teamwork is given in Appendix One (section 1.4). The picture is somewhat mixed, but overall it is possible to argue that teamwork can be effective in achieving positive changes in patient care. It is likely that, in apparently well-functioning teams, other factors

militated against successful outcomes, since studies from the health care setting looked exclusively at collaboration as the determinant of outcome.

3.6 SUMMARY OF ISSUES IN TEAMWORKING IN HEALTH AND SOCIAL SERVICES AND RECOMMENDATIONS

Working in teams is seen as an essential component of efficient organisation of the caring services. The organisational life of a team has been analysed as complex. What conclusions and recommendations can thus be made? The suggestions listed below are derived from the above-mentioned research studies and many of them, of course, appear to represent good common sense.

The main theme is not surprising: careful attention needs to be paid simultaneously to a number of factors to build a successful working team. Clearly, achieving positive results is not easy, as the multifactorial nature of the task militates against easy solutions. Nevertheless, a commitment from all the key players - professionals, their managers, the educators - is required. The process of change needs to be sensitive to the vested interests and personal costs inherent in changing patterns of working.

Individual issues identified as relevant to achieving success and amenable to IPE are outlined under the two categories of the structure and functioning of teams. These constitute the starting point for outlining the development of an IPE curriculum in Chapter Four.

3.6.1 Structural aspects of teamwork

Membership issues

Problems can arise if team members exhibit professional insecurity about the extent of their responsibility together with doubts about having an appropriate range of skills.

Interprofessional issues such as differences in educational preparation and conflicting views of other professions are important in this regard. They are correlated with:

- limited or different views of patient care and needs;
- use of professional jargon;
- differing or conflicting ideologies and values;
- and differing priorities.

Additional factors inhibiting professional accord are status differentials, problems of legitimate authority, and differences in power, including gender issues.

The roles within a team should be clear, and skills need to match the tasks. It is essential to avoid role ambiguity and incongruent expectations, or simply to avoid being ignorant of the role of other professionals.

3.6.2 Team functioning

Collaboration and communication

Communication between team members requires maintenance, and ideally communication should be easy and effective. The obstacles to interprofessional exchange need to be identified and removed. There ought to be a climate for collaboration, with a willingness within the team to change and develop.

Tasks

Tasks need to be managed appropriately. Enough time has to be allocated for their execution and work distributed fairly. Further, tasks need to be co-ordinated by interprofessional liaison, and differences in responsibility recognised. Tasks should be intrinsically interesting to avoid boredom and professional burnout. Team goals should be clear and members should be committed to them.

To achieve the required task orientation (Hunt, 1983) an agreement on team priorities needs to be clear and outcomes need to be evaluated. Problems can surface if there is a lack of commitment to agreed policies, or if different policies are followed by different professionals (Øvretveit, 1990). Planning of the team's work requires a needs assessment of the client group and team members subscribing to a congruent service philosophy.

3.7 THE PLACE OF INTERPROFESSIONAL EDUCATION

Successful teamworking depends on a mutual understanding of the roles and functions of different members of the team. One way of achieving this is to create the conditions for shared learning that would contribute towards better interprofessional communication and a more flexible use of the skills of team members. It should not be assumed that preparation for teamwork is unnecessary.

The chapter that follows explores in greater detail the role of interprofessional education and its potential contribution to teamworking.

4 CHAPTER FOUR - BACKGROUND: REVIEW OF CONTINUING PROFESSIONAL EDUCATION AND INTERPROFESSIONAL EDUCATION

4.1 INTRODUCTION

This chapter contextualises interprofessional education within the wider remit of continuing professional education. Five key questions arise. What is the changing context within which both IPE and CPE need to be considered? What are the policies that flow from the interaction of these context factors and actions of the key stakeholders? How is the process of developing new approaches to professional learning managed? What educational aspects of IPE are relevant to its development and persistence? And what is the evidence for the effectiveness of IPE?

The primary emphasis in this discussion is on IPE. Consequently CPE provides a backdrop against which IPE and its development can be seen. The literature review presented here does not exhaustively cover all the CPE issues, as IPE issues are given prominence.

The reader will notice that, while critically examining the literature, my stance in this chapter, just like in the previous, takes on a reasonably even-handed view of the key issues. Overall, I view teamwork, CPD and IPE as 'good things', that need to be promoted. A more critical interpretation of policy developments in these areas are presented in the discussion of the results in Chapters Seven and Eight.

Firstly, some definitions.

4.2 DEFINITIONS

CPE or CPD?

Where does CPE fit into the life of professionals? The initial stage of professional development gives a basic qualification allowing entry into the professions. The second stage, the post-qualifying or post-basic, allows the acquisition of a qualification or an award signifying a specialist status. Continuing professional education delineates the learning professionals will embark on as a part of life-long learning, while engaged in the performance of their duties.

As Hodgson (2000) pointed out, the idea of life-long learning emerged in 1970s, but did not enter the policy arena until the 1990s (see for example the Dearing Report into higher education

(NCIHE, 1997). The pressures for this move are the same as those underpinning the rise in interest in CPD - economic, technological and demographic changes requiring a different educational profile within all occupational groups. While life-long learning as an idea is a contested concept with different meanings assigned to it in different countries or by different stakeholders, within the UK the broad consensus is that it signifies learning that starts at the end of compulsory education, the aim of which is to enhance work-related knowledge and skills. Within the Dearing Report the emphasis is on the role of higher education, which makes it somewhat less relevant to the discussion here, for as will be pointed later, the CPE/ CPD base is in most cases outside higher education.

Eraut (1994) distinguished between CPE (provided by formal learning) and Continuing Professional Development (CPD) which includes learning from work experience. In recent years CPD has emerged as an alternative developmental strategy to CPE. This appears to fit in with the demand for a flexible professional, capable of taking on tasks not associated with the traditional content of a professional's working life. While CPE is concerned with updating the existing store of knowledge and the acquisition of new skills according to changing demands, CPD allows a professional to assume new roles. For example, a nurse who undergoes management training would be capable of moving from performing purely nursing duties to taking on responsibilities for running a team of nurses.

Interprofessional education

Interprofessional education is bedevilled by a lack of agreement on definitions and on the meanings associated with various permutations of labels, ascribed to different educational activities. Thus we see a plethora of labels used, such as multiprofessional education, interprofessional learning, shared learning, joint learning, multidisciplinary education and so on (Leathard, 1994). Notably, an expression such as multiprofessional education will mean different things to different writers. For some it would mean truly interactive learning, while for others it will signify shared participation at the educational event. Different organisers of learning claim that they offer IPE, while in many cases their definition of it differs from a mainstream one⁴.

One explanation for differences in the definitions used could be related to hidden interprofessional tensions. While IPE purports to facilitate interprofessional collaboration, differences in the

⁴ As proposed by CAIPE: Interprofessional education is an occasion when two or more professions learn together with the object of cultivating collaborative practice.

professional languages and conceptual constructs are displaced into disagreements about labelling and definitions.

For the sake of clarity and to further develop the arguments, I offer specific definitions of the relevant terms. The variety of meanings and their permutations will be explored in three stages: the designation referring to the shared learning experience (multi- or inter-), the range of occupations participating (profession versus discipline) and the learning (learning, education) itself.

The prefix of *multi-* in the context of learning is deemed here to mean participation in a learning event by professionals with differing occupational backgrounds. Shared and joint are given a similar valency here. *Inter-*, on the other hand, stands for learning whereby participants interact to some degree, where the implicit or explicit aim of learning is to learn about each other and from each other, and where the professionals serve as learning resources for each other. Thus interprofessional learning becomes a more clearly designated and defined subset of a wider range of shared learning opportunities.

A discipline, for the purpose of this discussion, is taken to be an academic discipline, not an occupational designation. Thus the preferred term (as a suffix) is a *-professional*, rather than *-discipline*. A profession here is meant a sufficiently distinct occupational group with its own tasks and roles, and professional body or interest group.

Finally, use of the terms education and learning needs to be addressed. While to some extent these terms can be used interchangeably, it is more appropriate to designate *education* as a concept describing the whole process, including the development of the curriculum, delivery of a syllabus and the learning process itself, while *learning* is more accurately used here to point to the professionals' experience of the process, their interaction with the material and with each other.

4.3 THE CONTEXT OF CPE AND IPE

What are the forces that shape the demand for CPE and IPE? Is it possible to arrive at a balanced view of the advantages and disadvantages of IPE?

4.3.1 Forces for change

Continuing professional education has assumed an increasingly important part in the lives of health care professionals. Principal reasons include the changing demands of the health service and the community care sector for the acquisition of new knowledge and skills, and the attendant changes in the definition of a professional's responsibilities. This is accompanied by the changing profile of professional knowledge which is required by professionals to perform their work competently. IPE additionally is seen as a potential contributor to the better functioning of interprofessional teams.

CPE, and IPE as an integral part of it, are now, as will be shown, entering the awareness of policy makers and educators.

Professional knowledge

The preceding discussion demands a more detailed examination of the structure and nature of professional knowledge. In what way is it different? Can it be described? Are the differences between professions understandable? Can these be overcome? A conceptualisation of professional knowledge is followed by an attempt to discern the interprofessional differences and is completed with a suggestion for unification.

A brief look at the issues offered here does not attempt to provide a critical analysis of this contested area. Barnett and Eraut are particularly helpful for discussion in this field.

Barnett (1990), while exploring the profile of knowledge for inclusion in the realm of higher education, made a useful analysis of key principles that can be extended to professional knowledge. Professional knowledge in this discussion is meant in a wider sense than just the representation of facts. As Eraut (1994) noted later, it is a conglomerate of theories, practical knowledge and skills combined with individual beliefs.

Barnett (1990) suggested that there are **five features of knowledge**:

First, it is an acceptance that knowledge does not represent an inert collection of absolute facts, but results from a 'dynamic discourse' i.e. it is socially constructed in interpersonal exchange. Second, he observed that a process of engagement with knowledge creation or acquisition demands a personal commitment. There is no truth 'out there', rather knowledge which needs to fit into the personal universe of the learner.

Third, Barnett, not surprisingly, suggested that acquiring knowledge results in personal development.

The last two characteristics of knowledge proposed by Barnett are also relevant to this discussion. Thus he suggested that there is a need to acknowledge that dealing with knowledge in its various ways (through research, teaching and in our case in practice) is value-laden. Profession-specific values inevitably impact on the selection, interpretation and reinforcement of knowledge in the process of professional education. Whose interests does the knowledge specified by the curriculum designer represent - that of the learner, the purchaser of the education, or the professional bodies validating the course?

An additional criterion proposed by Barnett is 'openness' - openness to discussion, and to challenge. The implications for IPE are immediate - each individual needs to be open to the questioning of his or her professional assumptions and to not ignore other perspectives.

A profile of knowledge as proposed by Barnett provides a refreshing challenge to the prevalent tendency in professional - especially medical - education to pride itself on the mastery of facts, and increasingly responds to the call for evidence-based action.

Eraut contributed to the discussion with his tripartite **classification of professional knowledge** (Eraut 1994) (p102) - propositional, personal and process knowledge. Another form of knowledge - 'action' knowledge - is explored as well.

Propositional knowledge includes discipline-based theories acquired without a specific context, generalisations and practical principles related to professional practice, and specific case-based propositions. This is the easiest class of knowledge to relate to traditional professional education, where distilled wisdom is handed down to novices as the foundation for their entry into a profession.

Personal knowledge is a more idiosyncratic amalgam based on unarticulated impressions, personal experiences and their interpretations. Here belongs the skill of pattern recognition. Case-based experiential knowledge can be acquired from two sources - formal (note that classic medical education was built on case-studies) and informal professional contacts.

Process knowledge, tacit knowledge or 'knowing how', refers to actual skills related to a professional's life and action. This type of knowledge may again be difficult to articulate as it becomes a part of an unconscious repertory of professional behaviour.

Another concept, that of 'action' knowledge, explains how a professional combines all of the above. An individual professional will continue constructing and reconstructing the specific profile of knowledge in a continued dialogue with the surrounding environment composed, among other elements, by colleagues, clients and political influences.

It is 'action' knowledge that determines professional action. Personal professional experiences are influenced by propositional knowledge which in turn helps to interpret its validity. Relying exclusively on propositional knowledge can result in cognitive blindness - it is easy to miss a diagnosis if one is unaware of the symptoms, or not 'listening' to a dissonance in a symptom presentation. Dissonance, in this instance, stands for a difference between the expected or learned set of features and the reality as presented by the patient.

What are the implications for professional education?

During professional education (at whatever stage) the professional and the facilitator need to be aware of these cognitive processes. A concerted attempt has to be made to make the interaction between the learner, the new material and the learning environment more conscious, so that the integration with an existing store of knowledge is harmonious and relevant. The key motive and intention is to avoid propositional knowledge staying at the 'espoused theory' level, or resulting in cognitive blindness.

Professional knowledge and interprofessional differences

The ideas of Barnett and Eraut outlined above permit us to postulate differences in the composition of individual professional knowledge.

Three writers - Beattie, Bines and Petrie - explored the idea of the structure of professional knowledge that begins to point to the origin of interprofessional differences.

Beattie (1995) noted (p19):

Studies in the structuralist anthropology of education show us that transformation in the structuring of educational knowledge can be strongly linked to changes in cultural values and social arrangements.

He suggested that a commitment to shared approaches to care offers an opportunity for professionals to develop common cultural values and to weaken professional boundaries. This loosening of the social identification with a 'parent' professional group can facilitate and be facilitated by shared learning.

Bines (1992a) (p128) pointed out that remodelling one's perceptions by accepting interprofessional work is a form of socialisation:

...though this time it is based in a complex interrelationship and synthesis of 'self' and 'other' into what 'we' might do together.

The problem-solving and practice-based approach that is relevant to professionals involved in IPE helps to develop a common frame of thinking. They move beyond the consideration of their own needs to the needs, aims and aspirations of the team of like-minded colleagues.

Petrie (1976) described in detail the 'cognitive maps' acquired during professional formation. For the principal elements of such maps for health and social care professionals see Table 4.1.

Petrie suggested that to overcome the obstacles to interprofessional work, each profession needs to learn about the other professions' cognitive maps. This means acquiring in an active interaction a sufficient amount of the other profession's 'tacit' knowledge to be able to communicate successfully.

- concepts of care, justice, equity and professional roles;
- approaches to problem description and definitions;
- observational categories and representational techniques that contribute towards perception and formulation of the issues and relationships in care;
- differing modes of inquiry, standards of proof and types of explanations defining the critical faculties employed in processing of information.

Table 4.1 Cognitive maps in health and social care

Comment

Professionals now operate in a fast-changing environment that requires a commitment to CPD. Boundaries between professions are blurring and this, together with the advances in medical technology, results in professionals taking on new responsibilities. Much closer attention is now given to the profile of professional knowledge required to perform a multitude of tasks, and employers are interested in transferable skills rather than theoretical knowledge.

4.3.2 Arguments for and against IPE

When discussing the advantages of IPE important qualifications need to be made.

The first qualification refers to measuring the outcomes of IPE. An underlying assumption in this discussion is that IPE achieves its aims. However, as is noted later in this chapter, this is not easy to demonstrate. Second, it is essential to identify precisely the role of IPE in professional education. Uni-professional education has a place both in the initial and the continuing stages of professional growth, as it provides an opportunity for the development of a professional identity and the acquisition of specialist knowledge and skills. IPE can provide the necessary links between these specific professional profiles of knowledge and identify the common and complementary nature of professionals' work.

With these reservations in mind, a description of the potential advantages and disadvantages of IPE is offered. Readers will note some echoes of Chapter Three's discussion on the advantages and disadvantages of teamwork. These links are in the nature of IPE, as its benefits or costs will impact on interprofessional or interagency collaboration.

A schematic summary of key advantages and disadvantages of IPE is presented in Table 4.2.

ADVANTAGES	DISADVANTAGES
Organisation of care	
improvement in quality of care (Thomas, 1994)	blame professional education for failure of policies (Funnell, 1995)
development of care guidelines (Humphris & Littlejohns, 1995)	inadequate or inappropriate guidelines
respond to service needs (Department of Health, 1992a)	
better use of resources (Barr, 1994)	efficiency rather than quality care
User orientation	
co-operate in decision-making	inappropriate delegation of responsibility (Greenwell, 1995)
better understanding of user needs and perspectives (Runciman, 1989)	
co-ordinate messages of team members	united front increases distance from the user
user empowerment	disempower user
user contribution to professional education (Kelly & Wykurz, 1998)	increase of user insecurity or loss of trust in professionals
Interprofessional co-operation	
learn about each other's work and, philosophies of care	
explore cognitive maps (Petrie, 1976)	
overcome stereotypes and prejudices (CCCPH, 1995)	reinforce stereotypes
improve mutual respect (Hughes & Lucas, 1997)	engender negative attitudes
enhance collaborative skills	increase workload with more cross-referral
improve problem solving	better co-operation lowers the output

ADVANTAGES	DISADVANTAGES
learn to divide tasks in teams effectively (Areskog, 1995)	negative outcome of skill-mix: delegation not teamwork, lower quality of care (Jenkins-Clarke et al., 1997)
Professional orientation	
better use of professional time	
able to lower stress (Obholzer, 1994)	increase mutual accountability and surveillance
strengthen professional identity	weaken professional identity (Conroy, Glascott & Cochrane, 1996)
professional development - flexible professional (National Training Forum, 1986)	
survival of the profession (Shaw, 1993)	loss of professional status
Educational orientation	
cost-effectiveness (Baldwin Jr, 1997)	more effort and time required (ENB & CCETSW, 1995)
survival (Barr, 1994)	desegregation of uni-professional educational hierarchies
breakdown interprofessional barriers in the faculty	need for new skills
for CPD - relevant education to service needs (Barr & Shaw, 1995)	needs assessment and curriculum development more difficult
	difficulties in applying new learning in work- place (James, 1997)

Table 4.2 Advantages and disadvantages of IPE

Balancing the arguments

The argument between positive and negative aspects of IPE appears to be finely balanced. The potential benefits of improved teamwork and a better quality of client-sensitive care surely cannot be disputed. On the other hand, beside raising challenges to educational providers, IPE might not be able to deliver the desired team changes. In addition, at least from the viewpoint of a well-established profession, such as medicine, it has the potential to undermine its professional status and power. However, as Francis and Humphreys (2000) argued cogently, the concept of lifelong learning challenges the professional barriers which prevent roles in the health care professions from developing more flexibly. In their view IPE has a key role to play in breaking down these barriers.

4.4 POLICIES AND STAKEHOLDERS IN CPE AND IPE

The context for continuing professional education is clear: the pressure to develop and to keep up-to-date is relentless. The system of professional education had to evolve to cope with these pressures, underpinned by the policies facilitating these changes. Who are the chief players on this scene? What are their interactions? How have the policies for CPE/ CPD and IPE evolved in response to the above-mentioned forces? The picture presented here covers the principal time span of this research, i.e. until the early part of 1997. Reflections on more recent developments are made in the discussion in Chapters Seven and Eight.

4.4.1 Stakeholders and their role in developing policies of CPE

The state

The Department of Health and NHS Executive (Department of Health, 1990b; NHS Executive, 1995a, 1995b; Department of Health, 1996c) have in recent years shown an increasing awareness of the importance of CPE/ CPD. One of the features of the introduction of market principles into public service is the deregulation of professional education and CPE. Its characteristics are the devolution of budgets with the associated responsibilities delegated to teaching institutions, and a reliance on quality assurance processes that focus more on output than on the process of learning. In the case of the health professions, the establishment and maintenance of the infrastructure is centrally funded, but the responsibility for actual expenditure on CPE is in many cases up to the employers or professionals themselves. Some of the central control is retained by providing a CPD

programme (NHS Training Division, 1994), albeit now under the control of a quasi-independent training agency (which until recently was an NHS Training Division).

Employers/ management

Health care managers also demonstrate, by the way they purchase education, a shift towards a more pragmatic, outcome-based orientation, due to economic pressures (Humphreys, 1994; Horder, 1995). Wright (Developing Managers for Community Care, 1994b) noted this shift, moving from 'service development' to 'performance improvement', where a major impetus is to maximise the staff's efficiency.

An example of this is the new role taken on by HAs in CPE of GPs and other general practice personnel. Some HAs have used economic incentives (development money, locum payments) to encourage GPs to attend teambuilding workshops, or practice development / planning workshops.

The other health care employers, the trusts, have always been involved in purchasing and providing education for their non-medical staff but now, through the education consortia, have begun to co-ordinate their purchasing plans. It is very likely that in the future CPE of medical staff will be considered in the same forums, as the NHS Executive has been actively encouraging co-operation between stakeholders in professional education, and has suggested that workforce planning provides a common denominator for considering co-ordination in this field (NHS Executive, 1997).

According to Hangartner (1996) CPD is easier for health managers to understand and support, especially as it extends to issues of management, communication and teamwork skills. It is clear that managers see CPD as a means of developing their workforce towards specific organisational goals, as they use the rhetoric of partnership or mutually reinforcing motives (Anon, 1995b).

Professions

Professional bodies subscribe to the notion of CPE as an essential part of a professional's working life (The England and Wales Working Party of Regional and Associate Regional Advisers in General Practice, 1989; Damant, 1990; CCETSW, 1992). Professional bodies see CPE as an insurance against performance standards slipping (Welsh & Woodward, 1989). The key motivation is to forestall a public critique of professional behaviour, or a move by the state to increase its hold over professional self-regulation.

The role of a professional organisation can be threefold (OECD, 1995). It can develop policies for CPE in collaboration with other stakeholders, it can be involved in the regulation of the professions through revalidation and it can provide CPE itself. In providing CPE, the professional body does not differ from other players in the education market. However, it would take the lead in offering courses designed for the acquisition of specific qualifications, namely those focussing on new advances or new directions for the profession. These might include management for GPs, nurse practitioner courses for nurses, or courses exploring key professional values, such as ethics.

Education providers

It is more difficult to discern a unified pattern of policy-making and action within the conglomeration of education providers. Multiple providers compete for this emerging market. This is related to the expansion of and diversification in HE (Pratt, 2001), and an increase in adult education and in the need for CPE. Thus three markets are identified in the OECD research (OECD, 1995): formal, informal and commercial.

The formal sector covers HE, including distance learning, and subscribes to high academic standards. The higher education sector until recently offered courses, primarily leading to a recognised degree or award, that gave the learners an opportunity to take on different roles, such as in management or teaching. Other areas relevant for CPE, namely those dealing with updating professionals in new advances, while always the province of the other two markets, are being addressed within HE-led CPE programmes.

Another feature of the educational market is the rising popularity of modular courses and the credit accumulation transfer system (CATS), which offer a flexible pathway for students wishing to acquire a further qualification or a degree. The move towards modularisation is not without its problems, however.

Eraut (1994) is critical of the CATS system (p10):

Such segmentation and packaging of knowledge for credit based systems seems inappropriate preparation for professional work which involves using several different types of knowledge in an integrated way; and the pedagogic approaches needed for linking book knowledge with practical experience are almost impossible to implement when there is little continuity of the membership of the student group.

The informal sector comprises professional bodies, employers, unions and non-profit-making organisations who themselves have developed successful training divisions and have a clear vocational orientation. The commercial sector delivers management training content. In the case of health workers, pharmaceutical companies support a wide range of courses as a part of their promotional activities.

Consumers

It is notable that there is little evidence of consumers being involved substantially in CPE. Some of the potential concerns of their involvement were already touched on when outlining the advantages and disadvantages of IPE.

However, it is clear that a substantial pressure on the professions stems from an increasing public awareness of health issues and a subsequent critical appraisal of the quality of care delivered. Patients have been involved over a period of years in the planning of the health service, albeit usually in a peripheral role. It is being recognised that they do constitute an important stakeholder group (Poulton & West, 1994). Their views are sought increasingly through patient participation groups in general practice (Pringle, Wallis & Fairbairn, 1996) and contracting for health care delivery requires the provider units to seek patients' views as part of the quality assurance process. Donabedian (1992) and Hopkins et al (1994) suggested that consumers should be involved in defining standards of care and thus become active participants in the audit process. In this way they could have a direct influence on professional learning.

4.4.2 Revalidation

How do these policies coalesce, and what is the interrelationship between the policies of these stakeholders? The idea and practice of revalidation is a prime example how professional bodies react to the changing policy environment. Revalidation carries with it a demand for compulsory CPE with it. How productive can such a pressure be?

Revalidation, recertification or reaccreditation of professionals is one of the core functions of the professional body. These terms are used at times interchangeably with, in my view, inadequate differentiation of their meaning. For simplicity's sake, and without implying it to be superior, I use 'revalidation' in this discussion⁵.

⁵ It is currently the preferred term used by GMC

The purpose of the revalidation is to maintain a register of the professionals who fulfil a set of requirements for continued safe practice. A move towards compulsory revalidation has arisen in the face of pressures from society for greater accountability and transparency of professional behaviour and self-regulation. Scrivens (1995) described a recent push for external control of quality standards that include calls for professional accreditation, but she pointed out the presence of a number of unresolved tensions. A trend, noted already, is for an increased degree of external control by the state while professionals are interested in self-regulation linked with education (Salter, 1998). Also, many of the current systems focus on processes rather than on the outcomes of care.

Some of the professions in the health care field are now obliged as a part of their revalidation process to document their CPE. The Royal College of Obstetricians and Gynaecologists requires its members to produce evidence of regular updating to maintain membership of the organisation (Ramsay, 1994). Midwives have to attend the equivalent of a refresher course (lasting five days) every five years. UKCC (NHS Executive, 1995c) has introduced similar requirement for nurses, who need to undertake five days of study activity in each three-yearly cycle of registration. They have to use, on a regular basis, a personal professional profiling system that identifies their needs, proposes how these are going to be met and records the advantages or disadvantages of any educational activity they have undertaken.

A move towards compulsory CPE

The central element of revalidation is in most cases, as seen above, the requirement to provide evidence of CPE. This opens up the question of compulsory CPE with its implied suggestion that not all professionals subscribe to the notion of professionalism and the maintenance of required and agreed performance standards. Other potential constraints are a lack of time or a disinclination to participate in CPE (Jarvis, 1983).

However, as evidence of the impact of CPE is mixed (Davis et al., 1995; Francke, Garssen & Abu-Saad, 1996), should it be enforced? Brookfield (1986) referred to the work of Cunningham and Hawking (1980) showing that **MCE** (mandatory continuing education) does not appear to have an impact on professional practice. On the other hand Todd (1987) (p11) pointed out:

A recent comprehensive survey of management attitudes and training activities in British private industry and in service sectors concludes that "on every single measure high business performance is strongly and positively associated with a high level of adult training" (IFF Research Ltd, 1985).

In the case of GPs in the UK an incentive to attend CPE was introduced with the NHS reforms in 1990. Having completed a requisite number of sessions per year, GPs can claim money withheld for that purpose from their remuneration⁶. The regulation can make a difference at least to some professionals taking up CPE. In the case of obstetricians it rose to nearly 100 percent from the 40 percent previously recorded (Anon, 1996). Experience in general practice is similar, as the number of GPs attending postgraduate courses has increased markedly since the introduction of PGEA (Kelly & Murray, 1996).

Debate continues about the loss of control over continuing education and its direction, and the implied loss of professionalism. Brennan (1990) argued that mandatory CPE has been introduced for the wrong reasons and to the detriment of the consideration of wider policy issues. The costs of mandatory CPE are considerable (Barriball, While & Norman, 1992) in terms of the time lost to service and to administering the system.

4.4.3 Stakeholders and their role and policies in IPE

Over the last thirty years interprofessional education has moved from being a peripheral to a central concern in the thoughts and action of the major stakeholders. These stakeholder groups active in CPE are described below, and their contribution to the development of IPE is outlined. What are the interactions between the stakeholders in policy development for IPE? Is it possible to discern the direction of change? Who are the prime movers?

The state

The earliest expression of interest in IPE at this level dates back to the 1970s. Two reports during that time mentioned in passing a need for shared learning as a means of clarifying team roles and achieving flexible working (Department of Health and Social Security, 1972; Royal Commission on the National Health Service 1979). In the latter report, mention of IPE can be understood in the context of its attempt to address the structural problems in the organisation of the NHS.

Under the Conservatives the welfare state began to change, due both to the altered economic circumstances and the ideology of New Right (see Chapter Two). The major changes in organisation of the NHS and Community Care (Department of Health, 1989b, 1989c) and greater

⁶ The so-called Postgraduate Education Allowance (PGEA)

attention being paid to specific care groups provide the backdrop for an increased interest in teamwork and IPE (NHS Management Executive, 1993). On the other hand, it is clear that the current and proposed structures for the commissioning of education (NHS Executive, 1995d) still maintains the divide between medical and non-medical education (Rogers, 1995).

Nevertheless, IPE began to emerge as one of the key strands in the NHSE's policy for development of the NHS (Department of Health, 1996c). Standing Medical and Nursing and Midwifery Advisory Committees (1996) suggested that IPE at all stages in professional development and clinical audit were tools to achieve the reality of teamworking.

The Government began to provide direct financial support for IPE courses designed to achieve the implementation of specific policies, such as Community Care (Carpenter, 1995). A wish to promote more comprehensive health promotion programmes run by general practitioners resulted in the establishment of HEA workshops, which by 1994 involved 8000 primary care professionals (Horder, 1995). These workshops allowed teams to explore under the guidance of experienced facilitators not only their plans for health promotion, but also their ways of working and interacting.

The child protection field received similar attention after a number of reports highlighted serious problems in interprofessional work (Department of Health and Social Security, 1974b; Cleveland Report, 1988). In response, a more co-ordinated organisation (Home Office et al., 1991) involving health, police and social services was introduced. Joint training has been established to facilitate such inter-sector work.

Employers/ managers

Employers of health and social care staff have also identified IPE as a way of complementing traditional uni-professional learning. The support, of course, has not been universal; old prejudices, especially from managers with a professional background, persist.

Two examples illustrate how regions have encouraged IPE developments. In the first case, an analysis of health care provision resulted in recommendations for both the purchasers and providers of education to consider IPE as a suitable format for integrating professional education and service provision (Hennessy, 1994). In the second case, one region has financed diverse IPE projects. These varied from employment-based to university-based courses, some with a more academic leaning, others focussing more on the needs of the work-place (Annandale, 1997).

Professions

For the last 30 years, professional bodies have led the way in working together to promote IPE. The first mention of IPE occurred in 1967 at a conference on teamwork (Kuenssberg, 1967).

A more co-ordinated approach can be traced to 1971 when the Royal College of General Practitioners (RCGP), the Council for Education and Training of Health Visitors (CETHV) and the Council for Training in Social Work, identified the need for shared learning (Royal College of General Practitioners & CETHV, 1973; Thwaites, 1993). Their recommendations to educators of the three professions for regionally organised meetings resulted however in only two initiatives (Lloyd et al., 1973; Hasler & Klinger, 1976).

In 1979, RCGP, CETHV, the Central Council for the Education and Training in Social Work (CCETSW) and the Panel of Assessors for District Nurse Training (PADNT) convened the first conference (England, 1980) to share the ideas and experiences of IPE. Held in Nottingham, this was a ground-breaking exercise as it gave the participants an opportunity to explore the key themes around IPE. These included its necessity, educational theory relevant to its success, obstacles to its establishment and practical issues of the resources required for running IPE courses.

Interprofessional education features in the policy documents of professional bodies in health and social care sectors (Royal College of General Practitioners, 1985; UKCC, 1986; ENB, 1990; UKCC, 1991; CCETSW, 1992; GMC, 1993). They recognise the need to promote the implementation of a teamwork approach by encouraging education providers to incorporate IPE into their curricula. Commitment to teamwork and shared learning is embedded in the initial training of social workers (CCETSW, 1991) and supported at the post-qualifying stage (CCETSW, 1992).

Co-operation in IPE between professional bodies

Horder (1995) documented the increased growth since 1987 of new interprofessional organisations concerned with the promotion of IPE in primary care. Their aim is to increase awareness of IPE and its place in the education of professionals at national, governmental and local levels. This could be done by organising seminars and conferences, establishing educational fellowships and supporting research into IPE. CAIPE (National Centre for Advancement of Interprofessional Education in Primary Care), was established in 1987. As a national organisation, it sees its role as a facilitator of discussions on many important questions about IPE: its role, value, contents and

modes of learning (Vancley, 1994). Other organisations of interest are ACT (Anticipatory Care Teams) (Anticipatory Care Teams, 1992), CONCAH (Continuing Care at Home) (Jones, 1995) and Health and Care Professions Education Forum (Health & Care Professions Education Forum, 1996).

There are a number of initiatives where the professional bodies co-operate in developing courses or co-ordinate their activities pertinent to teamwork and IPE.

ENB (English National Board for Nursing, Midwifery and Health Visiting) and CCETSW have collaborated on two major initiatives that are now well established. Support continues for courses with dual validation (ENB & CCETSW, 1995) for professionals wishing to acquire a joint social work and nursing qualification in order to work in the field of learning disability (ENB & CCETSW, 1990). Similarly, the course for practice teachers in both professions (Brown, 1993b) continues to be available.

The RCGP facilitated the establishment in 1992 of the Commission on Primary Care, whose membership includes the GMSC (General Medical Services Committee), RCN (Royal College of Nursing), Carers Association and NAHAT (National Association of Health Authorities and Trusts). The Commission deals with interprofessional issues and has launched a number of IPE initiatives, among them the Prince of Wales Fellowships which intend to stimulate IPE in specific areas such as learning difficulties, mental health, and the care of elderly (Styles, 1995).

These are, however, relatively infrequent examples of co-operation by professional bodies. If IPE is to develop a more solid institutional base, both organisational and attitudinal difficulties still need to be overcome before a sufficient number of IPE courses can be accredited by professional bodies. Organisationally it is not easy to match differently expressed learning outcomes in terms of knowledge, skills or competencies. Negative attitudes in the governing bodies of professional associations, even if not overtly acknowledged, can interfere with this process.

Education providers

The changes in the higher education sector noted above, namely the trend towards modularisation and the incorporation of colleges offering courses for nurses and other para-medical staff into HE, have enhanced its ability to offer interprofessional courses (Powell, 1996).

Support can now be located at the highest level of decision-making. The Higher Education Funding Council and the Committee of Vice-Chancellors and Principals (HEPC & CVCP, 1994) identified the need for close collaboration between medical and other health care professional education organisations, to jointly plan the strategies for the delivery and monitoring of education. This level of involvement represents the coming together of two forces - the responses to the market place and to central policies.

Another body representing the academic heads of the nursing profession ⁷ is more cautious. Its wide-ranging position paper on the education of nurses, midwives and health visitors recognises the potential value of IPE, but requests an evaluation of its effectiveness in enhancing teamwork and improving patient care (Council of Deans and Heads of UK University Faculties of Nursing, 1998).

4.4.4 Relationships between stakeholders

I now consider the relationships between the stakeholders.

There are the following permutations:

- The state and professionals
- The state and education providers
- The state and employers
- Professionals and education providers
- Professionals and employers
- Employers and education providers

The relationships between and within the stakeholder groups are complex. The degree of influence a stakeholder has over other stakeholders is played out through a process of legislation, negotiation and collaboration with other groups (McCann & Gray, 1986). Within a stakeholder group each of its constituents will have diverse motives and interests, and these will be expressed to varying degrees in interactions both within and outside the group. This section paints only a broad brush picture, which allows for a more detailed analysis of the data generated during the study.

⁷ Council of Deans and Heads of UK University Faculties of Nursing, Midwifery and Health Visiting.

The state and professionals

As a representative of the public, the state has an interest in improving the quality of professional performance and tries to influence the standards specified by the professional organisations. The autonomy of the health care professions has diminished in recent years with the growing importance of managers (Larkin, 1995). Nevertheless, the professional associations retain some influence on the government's policy formation, as they are represented on various policy-making or advisory bodies.

A greater degree of accountability has been introduced. For example, before claiming part of their remuneration for the care of patients with chronic conditions, such as asthma and diabetes, practices are required to show evidence of using protocols of care and auditing the care process. This increases the control over CPE by central government as until now only indirect means were employed, such as attempts to influence professional organisations to use performance indicators that included a commitment to CPE.

The state and education providers

Historical analysis of the relationship between the state and universities by Tapper and Salter (1995) identified three stages of development. The first is a collegiate model, characterised by convention and socio-cultural ties (between elites in government and HE). The second is a bureaucratic model from the mid-1970s, with economic retrenchment leading government to exert more control over universities. Direct investment in the development of departments of applied sciences was seen as important for economic progress. The last is the rise of the ideology of the managed market in the mid-1980s. This is characterised by closer financial control, a demand for accountability, and the introduction of quality assurance. This latter is enabled by the Higher Education Funding Councils (HEFCs) entering into contractual relationships with the universities, and the Quality Assurance Agency (QAA) monitoring the quality of teaching and organisation. The flexibility required by the government, of course, reflects its desire to make higher education more responsive to the needs of industry and the economy, and less focussed on the production of pure knowledge that has no direct application. Applied research and development is favoured instead.

Jarvis (1993) identified similar factors influencing CPD in organisations. The three key factors are:

- technological division of labour, where increased specialisation requires regular updating of the workforce,
- individuated society - with a more mobile workforce and less job security, a need arises for certificates as a passport to employment,
- and the bureaucratic state which has a need for replaceable individuals with specific competencies.

This is well illustrated by the 1996 White Paper (Department of Health, 1996c). CPE is seen as a part of the Government's commitment to life-long learning, but the focus is on learning that is linked to the strategic objectives of the service and allows the professional to be a useful member of the workforce.

The state and employers

Both the manufacturing and service sectors require a well-educated workforce, able to respond flexibly to changing external demands. This is true also for the NHS (Conroy, Glascott & Cochrane, 1996). The state's role is to facilitate this task through its links with HE and by supporting employers through financial incentives to enhance the educational status of its staff. A clear demonstration of this trend is the Government's support for competency-based education through its control of the NVQC (National Vocational Qualification Council) (see later).

IPE could be seen by employers as the delivery of the demand for a co-operative workforce whose loyalty might be more towards their teams than to their individual professions (Francis & Humphreys, 2000), and the state could then be seen as supporting the move towards the dismantling of hitherto jealously guarded professional autonomy.

The professionals and education providers

Relationships are changing between the education providers and the professionals with their associations. As the professionals become the purchasers of education, power is shifting away from the education providers. Consequently, the education providers are becoming more sensitive to the

learning needs of professionals and the demands of their work-places, and providing more user-friendly courses (Bines, 1992c).

The professional bodies are getting more closely involved in the accreditation of courses (Churchman & Woodhouse, 1999; Cameron, 2001). Education institutes collaborate in this task by mapping the curriculum and the learning outcomes or identified competencies of specific courses, based on the set of required standards or competencies issued by the professional bodies (Watkins, 1999).

The demand for degree courses and for flexible teaching, and the increased popularity of the modular approach, has encouraged the growth of IPE as provided by institutions of HE .

The professionals and employers

While until recently professionals maintained their professional competence without major interference from their employer, this situation is now changing. Systematic planning of the organisation's function requires closer co-operation from its employees, and their skills profile needs to fit in with the requirements of the organisation. This loss of autonomy is compounded by the loss of employment security in the current economic climate (Pinch, 1994).

Thus an employer could be commissioning IPE courses, or demanding an employee attend these in the interest of improving teamwork or their capability to assume different roles according to the required changes of the organisation. Work-based learning assumes greater importance in this context (Hull, 1993; Brennan, Kogan & Teichler, 1996).

Employers and education providers

As a consequence of the above, employers are more active in purchasing education for their staff, in influencing the design and content of the courses as well as showing preference for work-based learning. This is evident in the case of nurses and PAMs (Stanwick, 1994; NHS Executive, 1995d).

Weimar (1992) described in detail the background to the links between universities and industry. HE has a long-standing interest in working with industry in the field of undergraduate and postgraduate education including research. In CPE/ CPD this interaction is increasing, especially in the field of management and executive training, where the focus is on changing and developing organisational culture and management skills.

Research seems to suggest that employers now favour a much broader education focussing on problem-solving and interpersonal skills, that indeed may be more readily acquired in the interprofessional setting. This arises from a need to work in a more flexible manner across professions (Conroy, Glascott & Cochrane 1996).

4.4.5 Comment

Both CPE/ CPD and IPE have assumed a much higher profile over the last decade in the thinking and practice of the key stakeholders, namely the state, employers, professionals and education providers. This is seen in the plethora of supportive policy documents, legislating for changes in education provision, and the rise in mandatory revalidation. The relationship between stakeholders is complex, but a defining feature has been an increase in the influence of the state and the employers. Market forces have entered into these relationships.

4.5 THE MANAGEMENT AND ORGANISATION OF CPE

The organisation of continuous professional education (CPE), as seen above, is influenced by demands originating from society and the professions, from the employing organisations, and thirdly from the professionals themselves (Jarvis, 1983; Todd, 1987; Kenworthy & Nicklin, 1989).

What have been the major changes in professional education? How is CPE organised currently and is it possible to foresee future trends? Who appears to carry the major responsibility for the organisation of CPE?

4.5.1 Changes in professional education

A number of fundamental changes have occurred in professional education and in the higher education system itself that are relevant to this discussion.

The trend towards professionalisation in some occupational groups such as nurses is reflected in changes in their education. The apprenticeship approach based on skills training in the field has been abandoned in favour of having a stronger academic base (UKCC, 1986), that is seen to provide greater legitimacy to the professional status. This is accompanied by changes in the organisation of professional education such as the creation of health studies departments in HE institutions (Beattie, 1995) and the move of professional schools for nurses and professions allied

to medicine (PAMs) into universities. The specific cases of nurse and social work education are now examined in some detail.

Nurse education

The two new developments in nursing education are the advent of Project 2000 and the introduction of PREP (Post-Registration Education and Practice). What is the impact of these changes on practice? Project 2000 introduces nurses into a hospital and community work setting with a diploma level qualification but less hands-on experience. This inevitably puts an increased burden on existing staff to ensure that a new intake of staff nurses has an adequate opportunity to gain the required experience and it has necessitated the employment of health care assistants to take up the workload performed until now by student nurses. New regulations for post-registration education (UKCC, 1994) demand a structured form of evidence of continuing learning, which can include participation in audit and team learning.

Social work education

Two issues currently permeate the education of social workers: a shift towards a qualification-based profession and the re-configuration of educational outcomes in terms of competencies.

The first change has been the support for a larger number of social workers to acquire a qualification or a degree (CCETSW, 1992; CCETSW, 1996). The intention is to counteract accusations that unqualified staff were responsible for well-publicised failures in the care of children and the mentally ill. For experienced staff, a positive aspect of this move is an opportunity to gain recognition for their skills and knowledge acquired experientially.

4.5.2 The current situation and future trends in CPE

As noted already, the organisation of CPE is more diffuse in comparison with the initial or post-qualifying stages. Two explanations are apparent. First, historically CPE has played a minor role in the lives of professionals and much of its provision was ad hoc, offered by a variety of interested parties, such as professional organisations or employers keen to attract staff or develop them according to their needs. Second, the lack of statutory requirement until recently meant that CPE was not seen as a lucrative market by most of the potential providers. However, the situation is changing.

Providers of CPE for GPs include postgraduate medical centres traditionally based in hospitals but led by GP tutors, professional organisations which might organise courses nationally or through their local branches, and private organisations including pharmaceutical companies. In some areas, such as Scotland and the South West, the organization of CPE, at least for GPs, is more comprehensively organised through the regional advisors' network⁸. This diffuse situation reflects, partly at least, the independence of GPs.

For hospital doctors the situation has evolved somewhat differently. The major providers of CPE are university-based teaching hospitals and their professional organisations, the Royal Colleges. Private organisations play a much smaller role.

The nursing education structure is different again (Hennessy & Tomlinson, 1994). See Table 4.3.

The major difference for non-medical personnel is due to the greater say employers have over the funding and content of CPE (Rogers & Lawrence, 1993). Usually these professionals have to apply to the management for funding and be released from duty to attend study days, unless these have been organised by the management and made compulsory.

⁸ Or as currently named - Directors or Deans of Postgraduate General Practice Education. These organisational structures have a primary responsibility for post-graduate GP education i.e. Vocational Training, but have begun to play an increasingly important role in CME through appointments of GP tutors.

	MEDICAL	NURSING
Funding - source - management	DoH (PGEA) & MADEL ⁹ individual	DoH (WP10 ¹⁰), NMET ¹¹ individual employer & educational consortia
Professional bodies - develop policies	GMC, RCGP and other Royal Colleges	RCN, UKCC
- set standards	RCGP and other Royal Colleges	UKCC
- monitor standards	Regional Advisers network	ENB, UKCC

Table 4.3: CPE structure

Future trends

What impact are the pressures from employers and the government likely to have on the shape of CPE in the future? It is likely that the need to assure a high quality of standards in CPE organisation will result in higher education taking a more prominent role. Influential GP academics (Hannay, 1994; Rashid et al., 1994) suggested an integration of university departments of general practice with the regional advisers' network, to enhance the teaching quality of GPs through all stages - undergraduate, postgraduate and in the continuing education stage. Similarly the RCGP (1994b) has supported closer links between undergraduate departments of GP with CME. It suggested that the regulatory framework should be enhanced by nationally developed criteria and standards for CME. Some successes have been reported in the attempts to integrate undergraduate with postgraduate education through the use of audit (Bain, Scott & Snadden, 1995).

Jarvis (1983) (p72) argued that the continuing expansion of knowledge will require a more professionally organised CPE through institutions of higher education, rather than, as has been the tradition, by professional organisations.

⁹ Medical and Dental Levy - this is a levy on trusts against which they need to bid for their funds for CPE for hospital doctors

¹⁰ WP - Working Paper 10 specified how the funding for non-medical education and training ought to be organised (Department of Health, 1990b).

¹¹ Non-medical Education and Training - similar levy on trust for non-medical personnel, including nursing staff

4.6 EDUCATIONAL ASPECTS OF IPE

I now turn to the next stop of the IPE journey. How do all the forces outlined so far impact on interprofessional education, and how it is actually formulated? What are the issues in learning needs assessment that lead to specifying IPE as a suitable learning format? What learning outcomes can be derived from the needs assessment process and knowledge of teamwork problems? Why would a particular set of content areas be deemed suitable for IPE? And finally, what are the forces that help or hinder IPE in becoming an established part of the education providers' portfolio?

4.6.1 Learning needs assessment and IPE

The assessment of learning needs is a contested territory in education, but never more so than in IPE. Different perspectives and interests clash. The learning need of a professional takes on a different meaning according to who defines it and what purposes are served. These issues need to be explored to uncover the nature of conflicts permeating IPE curriculum development.

What is a learning need? At its simplest, a learning need represents the discrepancy between the existing and desired state of professional knowledge. The origin of this discrepancy is invariably external to the learner, but it needs to be translated into an internal feeling of discomfort or obligation to reach a desired level of motivation for learning. The demands of the external system include changes in knowledge, technology, political decisions in health and social care, and changes in demographic profiles. An analysis of learning needs arising from these changes provides a starting point for professionals wishing to survive and adapt through educational development.

Who formulates the goals of IPE?

The role of stakeholders in forming the profile of learning needs becomes clearer when we focus on a learner's intentions behind embarking on shared learning, or a manager's suggesting IPE as a learning modality. Scanlan's (Cervero & Scanlan, 1985) classification of CPE according to target and purpose of education is helpful for this purpose (see Table 4.4).

	Remediating Deficiencies	Fostering Growth	Facilitating Change
Individual	<i>Orientation 1</i> Updating/ competency assurance	<i>Orientation 2</i> Individual growth	<i>Orientation 3</i> Professional reorientation
Organisation	<i>Orientation 4</i> Employee training	<i>Orientation 5</i> Employee education	<i>Orientation 6</i> Organisational development
System	<i>Orientation 7</i> Systems deficit	<i>Orientation 8</i> Systems improvement	<i>Orientation 9</i> Systems reform

Table 4.4 Goal orientation of Continuing Professional Education

This classification allows mapping different stakeholders' perceptions of the need for IPE.

The principal stakeholders of the first three orientations are the professionals themselves and their managers. Orientation 1 represents the traditional learning need uncovered during appraisal or self-review, where a lack of teamworking skills might be causing a discomfort for the individual. Orientation 2 will come into play when a professional wants to augment his or her role in the team. Orientation 3 will appear for the professional keen to change direction and gain an insight into a new role and an understanding of how such a change will impact on their interaction with other professionals. An example might be a nurse taking on a managerial role: management-focussed IPE would provide an opportunity to learn not only management skills, but to test them out interactively with other participants.

For the next three orientations the stakeholders are the care organisations themselves. Orientation 4 implies an organisational need to equip employees to be better team players. Orientation 5 will emerge in the case of an enlightened employer recognising the benefit of a professional developing freely according to his or her own needs. Orientation 6 brings in the concept of the learning organisation (Davies & Nutley, 2000). The need for IPE arises in the case of an organisation wishing to undertake new functions, and to face new challenges requiring the reconfiguration of old habits and ways of interacting. An example would be the reorganisation of a community unit where the introduction of a flat management structure forces different professional groups to work more interactively.

The last three orientations have as stakeholders the policy makers at central government level, or professional bodies wishing to influence the whole system of care. Thus for Orientation 7, IPE might be deemed appropriate as an answer to inadequate and fragmented functioning in interagency work in the case of child abuse. Orientation 8 will arise when additional tasks need to be undertaken or the whole system of care is required to function more efficiently. This will materialise with increasing public demand for better organisation of care, say for the elderly or mentally ill. Orientation 9 is relevant in times of reform. This was evident at the time of the introduction of major reforms in health and social care in the early 1990s. As we have seen, IPE helped the establishment of new structures, such as new clinics in primary care for health promotion and care of chronic diseases, specifically for asthma and diabetes.

These orientations to needs assessment are not isolated from each other. Thus higher level demands impact on lower levels. For example, an organisation- or employer-centred needs assessment will be determined to some extent by the stimulus coming from the 'system setting' (Suter et al., 1984).

The identity of assessors of learning needs

Who should actually perform the learning needs assessment? The stakeholders are the learners, the educators and the employers (Todd, 1987; Pitts & White, 1994; NHS Executive 1995a; Sylvester, 1995). All of these groups have an interest in professional education and need to be involved in all stages of the educational process to develop a successful set of learning initiatives. Tensions are apparent. There is no assurance that the 'proper' balance between competing demands is achieved (Jarvis, 1983).

There is an observable shift away from the individual professional defining the aims and the content of learning on the basis of professionalism, to an employing authority translating an interest in the organisation's competitiveness and survival into a skill profile of the workforce (Developing Managers for Community Care, 1994b; NHS Executive, 1995a).

4.6.2 Learning outcomes and competencies in IPE

The needs assessment process will result in uncovering the learning needs of an individual professional or a team. To proceed with a curriculum design the learning needs need to be translated into more tangible outcomes of learning. These can be defined in either of two ways that complement and overlap each other - learning outcomes and competencies. Not surprisingly this

area of debate is contentious, primarily for difficulties in agreeing on the meaning and scope of these concepts.

Learning outcomes conceptualisation has its origins in the debate about the predictability of the impact of learning, and is clearly of a liberal flavour. As seen above, each professional will process learning and experiences in an idiosyncratic way, and consequently it is not possible to predict the outcome of learning engagement.

Competency conceptualisation, on other hand, has its origins in vocational training, with its intention of producing individuals with defined sets of skills. Specification of expected outcomes is tighter, and the requirement is for a greater reproducibility in the acquisition of professional knowledge. This approach to professional education, unfortunately, can have a behaviorist flavour - is the professional capable of performing the tasks and duties expected of them, can they be relied on to do them in a repeatable and predictable manner?

The analysis that follows shows, however, that there is a sufficient convergence in these two movements for us to consider them together, albeit whilst of keeping a critical eye on the inherent difficulties. By necessity, the outline of the debate is brief. The intention is not to debate critically all the issues pertinent to the subject, but to concentrate instead on the elements that illuminate the focus of the thesis - namely the influence of stakeholders on the conceptualisation of learning outcomes.

Learning outcomes

Currently, the prevalent formulation of outcomes of learning has moved away from behaviourally-defined learning objectives towards the notion of learning outcomes.

1	Work co-operatively in groups, share decision-making and negotiate with others.
2	Awareness and ability to adopt a variety of roles.
3	Listen to relevant opinions before reaching decisions and relate the ideas of others to the task in hand.
4	Evaluate the strength and weaknesses of group effectiveness and of own performance within it.

Table 4.5 Key transferable skills for teamwork

Allan's (1996) conceptualisation is comprehensive, and goes beyond a pre-specified subject content area by including other discernable outcomes of the educational experience. She divided learning outcomes into two groups – academic and personal. Generic academic outcomes cover areas such as the use of information, ability to analyse, think critically and synthesize ideas and information. The personal transferable outcomes include communication and organisational ability, collaborative skills and an ability to act autonomously. A number of desired IPE outcomes fall into these categories, such as the ability to work in teams, the ability to interact with different groups and the critical reflection so necessary for group learning. See Table 4.5 for details of teamworking skills (p108). Not surprisingly, these bear more than a close resemblance to the skills in teamwork described in the Chapter Three.

Competency movement

The debate about definitions, meanings and political implications of diverse conceptualisations of professional competence is vocal and complex. Why is this subject so important to a discussion of professional and interprofessional education?

A number of non-medical occupational groups, such as social workers, describe the desired outcomes of education in terms of competencies, and these also feature prominently in specifying the NVQ standards. A wish to have a competent cohort of professionals, and to be able to specify more precisely the range and quality of professional behaviour, characterises the employers of professionals in health and social care. In response to these pressures, terms such as competence, competency or competencies surface with increasing frequency in the critical writings of prominent authors on professional education such as Eraut (1994) and Barnett (1994).

The concept of competence

The two conceptualisations of competence described here represent a polarity between the more generic and the specific view of the elements of professional abilities.

Jarvis (1983) in one of the early attempts to analyse professional competency at the more general level has summarised its elements (see Table 4.6). Those in italics are relevant to interprofessional collaboration and learning and I shall return to these later.

Knowledge and understanding of:	Skills to:	Professional attitudes
- Academic discipline(s)	- Perform psycho-motor procedures	- <i>Knowledge of professionalism</i>
- The psycho-motor elements	- <i>Interact with others</i>	- <i>Emotive commitment to professionalism</i>
- <i>Interpersonal relationships</i>		- <i>Willingness to perform professionally</i>
- Moral values		

Table 4.6 The elements of professional competency

This conceptualisation, even if somewhat dated, is useful as it is sufficiently general to point to overall desirable areas of professional ability.

Conceptually, formulating professional competence at this level draws on what Eraut (1994) calls a generic perspective. It relates not to a specific task performance, but to more abstract skills and traits such as conceptualisation, and is concerned with the impact of one's action and self-control. Thus it has more relevance to professional education, as it takes into account the more complex world a professional has to deal with.

The second level of competency formulation hones down to specific tasks, and it is here that most controversies arise, as will be seen later. Advisedly, I use an example of a health care assistant to illustrate this situation. A health care assistant may become competent through the NVQ route to perform particular tasks, such as taking blood, making ECG readings or inputting data into a computer database. It can be seen immediately that a specification of behaviours in such detail bears a close resemblance to behavioural objectives. Tasks described at this level will be mostly in the skill area.

The behavioural concept of competence is linked to a competence-based training and in this country is associated with the NVQ (National Vocational Qualification) framework. By involving task analysis, the development of lists of competencies and their operationalisation can be quite sophisticated. It is based on a proposition that professional work can be successfully broken down into discrete, identifiable components devoid of the wider context and the complex interaction between diverse factors influencing the content and shape of the work.

A critique of the competency movement

Four issues spark controversy in this area - the political dimension, philosophical basis, practical and educational issues. Most of the critique refers to issues pertaining to the second, more detailed conceptualisation of competence. The political dimension of the critique is of major interest here, the other aspects, while important in their own right, are touched on only very briefly.

The political dimension of the competency debate

Who defines professional competence even at a more general level? Originally it was the remit of professional associations, who thereby controlled entry into a profession. Their unwritten contract with the government implied a maintenance of standards in return for autonomy in the profession's governance. Now we see other stakeholders questioning the freedom that professions have enjoyed hitherto to define their standards and police themselves.

The current trend is exemplified by the Government exerting control over required standards through the introduction of competence-based NVQs, and in the process challenging the autonomy of professions and their associations, with the additional incentive for the Government of the control of public expenditure. Jones and Joss (1995) suggested that a competency-based definition of profession (i.e. what is actually done by a professional) arises during the stage of societal development when managerialism is in the ascendancy.

Eraut (1998) identified an additional tension. The drive for competency-based qualifications is due to the government's desire to respond to the employers' need for workers with a range of competencies that will fulfil their particular work demands. This conflicts with the government's other intention of forging a flexible workforce, capable of transferring to different settings. However, context-specific skills may not be easily transferred to a different work situation. A simple example would be of a nurse used to taking blood with a vacuum device, needing to go on a course to learn how to use a traditional syringe method for the same purpose.

Further critiques of the competence movement

Philosophically, the competence movement challenges the humanistic view of education, as it demands a detailed pre-specification of professional behaviour and outcomes of learning. It does not allow for individual growth and for the inevitable development of professional knowledge and practice.

Practical problems abound. As Eraut (1994) pointed out, functional analysis produces a long document that tries to cover a wide range of situations within which a specific competence would need to be demonstrated. Attempts to apply this approach to higher degree levels of professional education has been bedevilled by the difficulties in trying to concretise the more abstract cognitive abilities.

Educationally, the competence movement devalues discovery learning and the role of the teacher as a facilitator of personal and professional growth (Barnett, 1994). Education becomes training for the purposes of satisfying the performance assessment process.

4.6.3 The link between learning outcomes, competencies and IPE

The stance taken here on competencies is broad. It relates more closely to the more general level of competence conceptualisation which integrates an interplay of a range of knowledge, skill, attitudes and values. Competencies thus defined cover all aspects of professional 'action' knowledge relevant to professional practice.

For the purposes of this discussion I propose to consider learning outcomes and competencies sufficiently overlapping concepts to use them interchangeably, even if in slightly different contexts. Learning outcomes would tend to describe the intentions of the learning provision, whilst competencies would appear more frequently in the context of professional behaviour and capability.

The ability to work in the interprofessional setting requires interpersonal skills and a team capable of exploring professional roles and boundaries. This suggests the need for an IPE format.

Teamwork and learning outcomes

How can various problems in teamwork be addressed? Clearly, a number of them are outside the potential remit of education. Education's role, in cases where teams are challenged through external environmental pressures, new legislation or poor management, is to make the professionals more adaptable. Nevertheless, there is a range of issues identified in Chapter Three that offer opportunities for learning. While there are aspects of teamwork that are common to any group, and thus could be addressed through teambuilding, the primary interest here is to suggest how specific interprofessional issues can be translated into learning outcomes.

The issues pertaining to members of the team and team function belong here. (For further detail see Appendix Two Table AP 2.1.) The working hypothesis used here is that these learning outcomes can be addressed only in interprofessional exchange, with adequate space for group and individual reflection to incorporate such learning into the individual's 'action' knowledge.

These learning outcomes could be distilled to those relating to knowledge, skills, attitudes and values in professional life and teamwork.

Knowledge: a need to understand other professionals' roles and their cognitive maps and to understand issues in teamwork.

Attitudes: while there is a need to strengthen one's own professional pride, at the same time it is important to learn to respect others' worth and capabilities. Positive attitudes and commitment to teamworking are to be encouraged.

Skills: working with others requires co-operative and negotiating skills.

Values: uniting all of these categories is the commitment to continued learning and development within the interprofessional environment.

How do these learning outcomes interact with competencies? Let us refer back to the list of professional competencies as described by Jarvis (1983) (Table 4.6). Those that were highlighted in italics as relevant to teamwork overlap with those summarised here. This competency formulation is congruent with the cognitive approach as these are expressed in terms of knowledge, skills and attitudes.

4.6.4 The content of IPE

How can the range of learning outcomes identified above be translated into learning opportunities? What distinguishes IPE from other educational offerings in terms of its structure and content? The primary distinction, it is suggested here, is the key objective of IPE - to enhance interprofessional co-operation. This intent informs the process of curriculum design, as the interactions between different professions have to be made overt and opportunities created for participants to reflect on these interactions. The exact content in a sense is immaterial, as long as every occasion for learning about each other is exploited.

Types of IPE content

What type of content is it possible to discern and what characteristic topics lend themselves to the IPE format? Content in this discussion is intimately linked to an underlying educational intention and will be concerned with the learning outcomes described above. Barr's (1998) tripartite classification of competencies can be usefully transposed in this context into considering IPE content under the headings of common, complementary and collaborative content.

Common content will cover issues of common concern or professional need, for example the diagnosis and treatment of asthma or the management of change. However, it is the intention to learn about each other's ability and the need to collaborate in asthma care or in introducing innovation in the interprofessional setting that converts it from MPE into IPE.

Complementary content will have as its aim to allow different professionals to learn about other disciplines' structure of professional knowledge. Such content may not be of direct operational significance to their uni-professional functioning, but is clearly relevant in interprofessional contact.

Collaborative content will specifically focus on knowledge, skills, attitudes or values that promote the collaboration. Teambuilding exercises fulfil this intention. Clearly this classification is not meant to be watertight.

IPE topics

Specific IPE topics can be divided into four groups: those concerned with health and social care issues, those underpinning professional issues, management related topics and those orientated to teamworking. It can be appreciated that all of those can be offered on a uniprofessional, multiprofessional and interprofessional basis. None of them are specific to IPE, and it is the intention, the learning outcomes, that determine their validity as IPE. To illustrate the type of topics and how these can fulfill interprofessional intent, one of the groups is outlined in detail.

Health and social care issues that are amenable to an interprofessional education format include:

- health prevention (Lucas, 1990),
- diseases such as diabetes mellitus or asthma, mental health including drug abuse, AIDS, cancer and terminal care (National Council for Hospice and Specialist Palliative Care Services, 1996),
- age-specific topics, namely care of elderly (Pomeroy & Philp, 1994), maternity, and child abuse,
- societal issues, including those pertaining to ethnic minorities, unemployment, housing (Tope, 1996),
- primary care problems.

In an example of terminal care, all three content types can be present.

Common:	all the professionals present will want to learn about new approaches to pain management;
Complementary:	GPs might want to appreciate skills of managing syringe drivers by district nurses;
Collaborative:	both professional groups can rehearse collaborating, in sharing responsibility for the total management of challenging situations.

4.6.5 Comment

In this section I focussed on the role of different stakeholders in the curriculum process of interprofessional education. The main argument I put forward is that professional education is not a neutral enterprise. It is seen as part of the governance of the professions, and thus each stakeholder will want to influence its shape, from defining learning needs to prioritisation of content. Recent years have seen a substantial shift in the focus of influence from the educational establishment and professions to the managers and the state. This is well illustrated by the rise of the competency movement, which threatens the liberal, developmental orientation in professional education.

4.7 FACTORS PROMOTING AND INHIBITING THE ESTABLISHMENT OF IPE

Research literature is silent on the factors in the wider political and social context of professional education that impact on the existence of interprofessional education. This, of course, is the *raison d'être* for this thesis. Research does offer insights into three areas relevant to IPE's emergence, namely the factors pertaining to individual professionals, the education organisation and the workplace.

4.7.1 Individual issues in IPE innovation

What are the factors in the make up of individual learners that need to be taken into account when planning an IPE activity? These fall into two groups. The first relates to their individual background and experience, such as attitudes to IPE, or differences in the stage of knowledge and training reached. The second refers to professional issues, such as different cultures or values. Table AP 2.2 in Appendix Two summarises these factors and the sources of evidence supporting the contention of their importance. It is clear from the list that the presence of these factors has a negative effect on the adoption or success of IPE. I have not identified any published evidence of IPE organisers dealing successfully with these issues. This should not be a discouraging sign, as it is possible that adequate research documenting positive outcomes in this domain has not been published as yet.

Two reports illustrate the above points. Loxley (1980) in her survey addressed the issues of low doctor participation in IPE activities. Besides overt differences in knowledge and intellectual skills, many reasons derive from the process of socialisation into the medical profession that still forces doctors to develop psychological defences to cope with the emotional stresses arising from patient contact and that prevents them sharing these stresses with others.

A report of the experiences of running child protection courses for health and social care professionals (Stanford & Yelloly, 1994) highlighted the problems inherent in the heterogeneous composition of the participant group. The extent and experience of prior education presented the course organisers with a challenge in how to cater for individuals with different expectations of learning formats and frames of thinking. Whilst the social workers were accustomed to process-based, exploratory learning, where a degree of uncertainty is tolerated, the health care staff expected more didactic teaching.

4.7.2 The education organisation factors and IPE

The factors involved in curriculum development and the supporting evidence is summarised in Appendix Two, Table AP 2.3. These can be divided into: issues pertaining to learning needs analysis, an underlying educational philosophy, planning and organisational factors (such as time, funding, balance of professions), and those relating to staff (such as negative attitudes to IPE or lack of experience). Problems, as shown in the studies cited, can jeopardise the development and implementation of IPE courses.

Some of the above issues have been expanded upon, one using an example of a university and another looking across regional efforts.

Lucas (1990) demonstrated at Salford University how careful planning, using a pilot study to detect potential problems and a needs analysis, helped to construct a successful course. A number of problems were uncovered during the pilot phase. For example, a subject scheduled in the first year might have been more logically located in the second year, by which time the students would have been better prepared theoretically. Interprofessional tensions in the faculty emerged - these were manifest in the persistence of incompatible teaching strategies and in the lack of modelling of co-operation to the student body.

Shakespeare (1997) reported on experiences of IPE programmes in two regions. In the South & West Regional programme, the main obstacles in the educational domain were a resistance to change including tribalism and an insufficient integration of IPE into the mainstream of professional education. In East Anglia developers needed a long time to overcome obstacles of professional identity bound up with the educational framework. They found that working through these professional boundaries using a process of clarification helped staff learning.

4.7.3 Work-place organisation factors and IPE

The work-place has two functions in regard to IPE - it provides a stimulus for learners to take up IPE and an opportunity to apply their learning. In this way, there is a dialogue between practice and learning, and, optimally, an intimate involvement with the education provider ensures the relevance of learning. Managers need to provide a supportive framework for the professionals, as IPE challenges set views on professional roles.

The factors that promote or inhibit these functions divide into five categories. These relate to problem identification (as a part of learning needs assessment), to the resources required both for learning and the application of it (time, opportunities for team meetings and differences in organisational cultures), to the internal processes of the work-place and those describing internal (quality of teamwork) and external contexts (such as interagency collaboration). Table AP 2.4 in Appendix Two lists these with relevant references.

Two studies permit enlarging on some of the work-place related factors. Both involved a number of sites.

Spencer, Pearson et al (1993) described a project designed to facilitate an interprofessional audit in five general practices. The educational input was in the form of away-days and visits to practices by a facilitator. While the participants felt that the exercise was helpful in introducing change into their practices, a number of problems emerged. These were: a lack of time to implement the original intentions in initiating the audit as other priorities took precedence, difficulties in involving everyone and other communication issues; difficulties in maintaining the momentum of change; and a lack of space.

Brown's review of the Joint Practice Teacher's Initiative (Brown, 1993b) identified key factors for success. The project design had to be appropriate to the needs and priorities of the commissioning organisations - the local authorities. Collaboration throughout the project was required between the education designers and the management in local authorities. Local support for those leading the change was crucial in allocating adequate time and funds.

4.7.4 Comment

Inevitably, a multitude of factors need to be favourable for the introduction and survival of any educational innovation. As IPE involves different professions, the challenges are multiplied. Positive attitudes to IPE need to be present at all levels - individual, teacher and management. Likewise organisations, both teaching and work-place, need to be supportive of such changes.

4.8 EVALUATING INTERPROFESSIONAL EDUCATION

The final question of this chapter is a crucial one. What is the evidence that IPE works? And how can we define effectiveness in education? Pirrie et al (1999) argued it is difficult to make links between IPE and patient outcomes. Nevertheless, the question is real. In the current climate of

financial restraint, education is seen as an instrument to deliver desired changes in the services by altering the behaviour of professional staff. Thus, can the funders be persuaded that IPE is a worthwhile undertaking so that they will identify new funds for it or divert existing monies from uniprofessional education?

Forty-nine studies have been included in the analysis of IPE effectiveness in this chapter.

Summarising the impact of IPE initiatives

Table AP 2.5 in Appendix Two presents an overview of the balance of evidence of the effectiveness of IPE. The studies are classified into three categories by methodology:

- experimental controlled - these include randomised controlled trials (RCT), controlled before and after (CBA) or other matched studies, and interrupted time series (ITS) studies that have at least two measurements before and after the educational intervention;
- other experimental - these include BA studies and post-event comparative; and
- post-event quantitative and qualitative research.

The outcomes are divided into impacts on knowledge, attitudes, skills, behaviour, patient outcomes and organisational change, and are further divided into three sub-groups - positive, neutral and negative. No distinction is made between stages of professional development.

Comment

What conclusions can be drawn from these studies? A quick glance at the table AP 2.5 (Appendix Two) could suggest that IPE is effective. In all the outcome categories the accumulation of the evidence appears to be in a positive direction. There are some, but fewer, studies showing no change or even a worsening of the attitudes or behaviour. However, if only the most rigorous studies (i.e. those in the first column - the controlled experimental studies) are accepted, the picture looks less certain.

4.9 SUMMARY

This chapter has broadly reviewed the changing scene of CPD and IPE to provide a background against which the empirical data can be analysed. As mentioned in the Introduction, critical reflection on the principal issues raised in this chapter is given in Chapters Seven and Eight.

4.9.1 Continuing professional education and IPE

Firstly, I have traced the key forces that shape the changed professional education scene. Besides the changes in the societal context already outlined, the remit of professional work is changing, as is the shape and content of professional knowledge. This is reflected in changes to professional education at the pre-qualifying stage. Nurse and social work education is becoming more academic, with social workers' education becoming competency-based, and problem-based learning and the reflective practitioner model becoming an integral part of medical education. This inevitably has an impact on the profile of education at further stages of professional development. Awareness of the foundations of professionals' knowledge, its multifaceted composition (propositional, personal and process (Eraut, 1994)) and interprofessional differences are essential for building relevant programmes of professional and, especially, interprofessional education. The challenge for teachers and learners alike is to become familiar with the different cognitive maps (Petrie, 1976) that define a specific professional group and its actions.

While the argument for CPD is unquestionable, the debate about IPE is very much alive - and I have presented a succinct summary of arguments for and against the introduction of IPE. I have suggested that the balance between these arguments is a fine one and that enthusiasm needs to be tempered with an awareness of potential problems and other issues, such as the questionable degree of certainty about the effectiveness of IPE.

4.9.2 Developing the curriculum for IPE

I have not provided a practical guide to developing an IPE curriculum. Instead I have explored the mainly theoretical foundations of the various steps, from learning needs assessment and specifying learning outcomes, to suggesting areas of professional learning suitable for IPE. The main focus has been on issues that were going to be addressed during the empirical stage of the research, namely those pertaining to stakeholder involvement in IPE.

Thus, I have outlined how employers are increasingly getting involved in learning needs assessment for CPD and even more so for IPE, as they claim that well-functioning teams are essential for the smooth running of care organisations. The focus shifts from augmenting individual development to fulfilling the organisational imperative.

I have given some attention to the role of the competency movement in considering the range of appropriate learning outcomes for IPE. I have noted that one reason for the rise of this movement is due to employers wishing to have a greater say in defining the profile of professional knowledge and behaviour. I have suggested, nevertheless, that a broader definition of competencies combining underlying knowledge, skills, attitudes and values is appropriate for the shifting world of teams. This is because issues relating to team members or team function need to be addressed in a more global, flexible fashion.

4.9.3 Factors influencing the establishment of IPE

I have drawn on the research evidence to compile an overview of the factors that promote or inhibit the establishment or persistence of IPE. The need for such knowledge is supported by the experience of those few IPE courses persisting for any length of time (Barr & Waterton, 1996). Not surprisingly the raft of issues was extensive. It was interesting to note that factors pertaining to individual learners, such as attitudes to IPE, or differences in professional values and cultures, have been documented as having only a negative impact. Educational organisations face a number of challenges, ranging from how they approach a learning needs assessment, differences in educational philosophies, issues in planning and organisation (such as resources or co-ordinating timetables), to staff issues. The work-place inevitably plays a crucial role in IPE. Despite an interest by employers in developing their staff, obstacles can surface. These range from an inadequate identification of a problem that IPE may address, or not giving sufficient support in terms of resources, to negative attitudes of fellow workers or managers.

4.9.4 Evaluating the effectiveness of IPE

An appraisal of the evidence appears to imply that IPE might be effective in improving participants' knowledge and changing their attitudes or behaviour, it could even impact on patients. However, a stricter method of analysis belies that conclusion. Further doubts are thrown up by the considerable methodological problems in IPE evaluation, such as poor returns to questionnaires or a lack of evidence that changes in learning or behaviour persist over time.

5 CHAPTER FIVE - THEORETICAL PERSPECTIVES

5.1 INTRODUCTION

The process of selecting a theoretical framework was developmental, as is characteristic of reflective research. Thus, there was a continuous cycle of reflection in moving between the aims of the research, data collection and analysis, and testing out the relevance of theoretical perspectives.

The theoretical perspectives chosen fall into two broad groups - the positivist and poststructuralist. The reason for choosing more than one conceptual perspective and different paradigms was the need to create a fuller picture, and to illuminate the area studied from a range of angles, thereby avoiding accusations of theoretical fundamentalism. I develop the argument for use of a theoretical triangulation (Denzin, 1970) further in Chapter Six.

5.2 MODERNIST OR POSITIVIST THEORETICAL PERSPECTIVES

Three groups of theories were chosen: theories of power and policy-making, innovation, and adult learning. The postmodern perspective presented in the next section provides an alternative framework, but in the case of adult learning is used here as its critique.

What is the specific contribution of these three theories? Firstly, in the interactions between stakeholders in the welfare services and in the education of welfare professionals, issues of power, control of resources and influence on the policy process emerge repeatedly. Secondly, innovation perspectives are useful at looking at the processes of change, as they postulate much clearer causal relationships and suggest that it is possible to identify factors contributing to the current state of affairs. Thirdly, adult learning theories throw light on the processes of learning and the organisation of IPE and CPD.

5.3 THEORIES OF POWER AND POLICY-MAKING

5.3.1 Power perspectives

Two theories on power in society became central during the process of analysis - hegemonic and pluralist. Other conceptualisations of power exist (see for example Clegg (1989)), but I have found these two most helpful in explaining the distribution and use of power by the principal stakeholders.

What is power and why is it important to look at it in this work? Taking this perspective, power is the ability of one agent to have influence over another and their actions, and an ability to alter the societal and organisational structures within which the object of power operates.

I draw on Clegg's (1989) comparison of three models of power (p105), and for simplicity this is presented in table form (Table 5.1).

	Models		
	Pluralist	Elite	Class dialectical
Processes	competition	hierarchical dominance by elites	imperatives of social class, domination and conflict
Key actions	interest group competition	hierarchical dominance	class domination
Resource for power	organisational, governmental, economic, social and personal bases	institutional position, common social background and convergent interests	class position and degree of class consciousness and organisation
Distribution of power	dispersed among competing groups	concentrated in hegemonic elites	held by dominant class, potentially available for subordinate classes

	Models		
	Pluralist	Elite	Class dialectical
Stability of power	limited - shifts of alliances, need for consensus	stable - no limits for domination by elites	historically determined - strong, but open to challenge in the class conflict
Role of state	as a broker - balancing competing interests	little autonomy - elite is dominant	serves the interests of the dominant class, with some autonomy to preserve the basis of class hegemony

Table 5.1 Models of power

I do not propose to describe in great detail the history of these concepts of power and their different formulations. Instead, more pragmatically, I focus on those conceptualisations that have proved useful in my analysis. I address the hegemonic concept of power first, as from the above table it may not be apparent why the hegemonic model is not clearly identified, and why I have found the elite and class dialectical models particularly useful for my concept of hegemony.

The hegemonic perspective on power

Gramsci (1971) developed a concept of hegemony to describe how a social class is able to develop and maintain a dominant role in society. The kernel of his analysis is that dominance is achieved not only through coercion but also, and more importantly, through acceptance of its ideological and moral stance. Gramsci (1971) talks of an 'integral state' (p263) where these two forms of power are integrated seamlessly.

The state is identified with the currently dominant class and its philosophical profile. This hegemony is arrived at by communicating its world view, its interpretation of how society and the state ought to be run, through the media and the school system. Hegemony of a given class is not a stable condition. A struggle for dominance is fought in the ideological arena. Thus it could be said that the ideology of New Right was hegemonic during the rule of the previous Government,

while the philosophy of the 'Third Way' as propounded by the current Labour Party is dominant now.

Bocock (1986) pointed out the weaknesses of the original formulation, as Gramsci based his analysis on the then prevalent forms of capitalism and socialism. Capitalism, as a state ideology, has since proved to be a resilient form of hegemony, able to maintain its appeal to the majority of the population and persist as a form of governance.

It is now possible to see that Gramsci's ideas are presented succinctly in the 'class dialectical' model of power in Table 5.1.

Where does the elitist model of power fit in? The concept of hegemony I wish to advance differs from the one described above, where it is linked with the dominant social class. I have taken the liberty of identifying the managerial class as the newly dominant group or 'class' within the institutions of the welfare state. The power that it has assumed is consonant with the hegemony of the ideology of the marketplace, that is characteristic of the current development of the capitalist system.

This concept of the power group combines some features of the 'elite' model and the 'class dialectical' model, inasmuch as the elite is the management class that has become pervasive in the new welfare state and is in conflict with the professional class. Whilst this is not an accepted view of the social classes, it serves the interest of this analysis well. The hegemonic formulation of power discussed here implies that the professions and the educators are the groups over whom power is exercised within the new economic order.

The pluralist model of power

Pluralism appears to be the dominant theory in political science. Classic pluralism is best seen in liberal parliamentary democracy. Democracy, in this view, provides an opportunity for any group to seek to influence society through direct representations: that is, elections or pressure on those with a representative role. The essential feature of this model is the visibility of power that is dispersed among the interest groups.

Smith (1995) (p209) was, however, critical of classic pluralism, as represented in Table 5.1, since it implies an equal access to power and representation by all the groups in society. Dahl (1961), one of the most prominent theoreticians of the pluralist model, acknowledged that not all groups,

and not all citizens, are active and seek to have power. In addition, not all groups have the resources - human, organisational or financial - to pursue access to power successfully.

Smith further pointed out the key methodological issues relating to the analysis of only observable behaviour. Consequently, some of the later variants of pluralist thought look for hidden evidence of power. Also, the classic pluralists ignore the role of ideology on the thinking and behaviour of key players in society.

For the purposes of this study, however, I use the classic formulation of the pluralist model as it contrasts with the hegemonic concept.

5.3.2 Policy-making theories

I outline here briefly the main theories that I have used to analyse the policy processes. In addition to expanding on the pluralist model and my formulation of hegemony, I outline a systems model of policy-making.

Pluralist and hegemonic models in the policy process

It is relatively easy to see how and why I have used the above power analysis frameworks. Location of power determines the influence on this process. The pluralist model predicts that a multitude of interest groups will be involved, even though some will have a greater degree of access to decision-making at the centre. On the other hand, the hegemonic model suggests that a class or an occupational group will hold the prevalent ideas on the running of the state and its institutions, and thus will be in a better position to shape the policy process.

Justifying the use of multiple theoretical models

I would like to suggest that different explanatory models are suitable for different stages of development of the relationship between the state and the institutions of the welfare state. In other words, a pluralist model might be appropriate for a situation where the state does not take direct control of these institutions, and a hegemonic model for when the state works with an institutional group that shares its philosophy.

Support for the validity of accepting multiple or sequential context-dependent models comes from analyses of the relationship between the state and public institutions or professions, and of policy-

making in the NHS. As mentioned in Chapter Four, Tapper and Salter (1995) outlined a proposition that three different models needed to be used to explain the development of the relationship between the state and the education system. These were a collegial model (in effect an elite model), a bureaucratic model and a market model (this correlates with my hegemonic model).

The same profile of models is used by Shaw (1993) when analysing the relationship between the state and the professions. He argued that, over a period of time, a strong tradition of professional associations evolved the concept of a profession in co-operative dialogue with the state. Bureaucratic control of the professions, so characteristic of continental Europe, appears to have been adopted with the rise of the welfare state, as the government became increasingly interested in those professions acting in the public sector (such as medicine, law, engineering and teaching). The last stage of the development of the relationship between the state and the professions is the adoption of managed market principles.

The policy-making framework

What other models appear to be useful and relevant?

Ham (1992) looked at a systems model of policy-making as proposed by Easton (1965). This model suggests that it is possible to understand the process of policy-making by looking at the inputs (support from electorate, taxes, and compliance or otherwise with the laws of the land), outputs (policies) and the process of policy-making by the central body. Thus the activity of central government occurs in the social and political environment with which it interacts. The openness of the system makes it capable of responding to the various influences in its environment, and to the demands or reduced support that might threaten its stability. Government does not create its policies in a vacuum. It must take into account the electorate as well as powerful or vocal interest groups.

The systems approach model, as Ham pointed out, has a number of faults. Firstly, it does not take into account the policy-making ideology of the governing party. Secondly, it ignores the issue of who is the beneficiary of the stability of the state apparatus. It also does not examine the role of power in the system, its location or impact. Lastly, it does not throw any light on the policy-making process itself, on what the forces are at play within the government.

Nevertheless, I would like to suggest that the systems model is complemented by the pluralist and hegemonic models, as these do take into account issues of power, ideology and group interest.

5.4 INNOVATION THEORIES

Innovation theories have been used to analyse the data where a central feature is changed. Thus they are relevant when considering the changes in the welfare state and what factors influence the introduction and persistence of an educational innovation such as IPE.

5.4.1 Definition

West and Farr (1990) proposed the following definition for an innovation (p9):

...the intentional introduction and application within a role, group or organisation of ideas, processes, products and procedures, new to the relevant unit of adoption, designed to significantly benefit the individual, the group, organisation or wider society.

5.4.2 Theoretical issues

Two sets of theoretical writing on innovation are presented. The first one originates in sociological research and has been a mainstay of writers on educational innovation, and the second draws on research on innovation from social and organisational psychology. It is worthwhile bearing in mind the conclusion by Van Vucht (1989) that the proliferation of theories of innovation suggests the impossibility of providing an unequivocal framework for analysis - which, in my view, justifies a pragmatic, eclectic approach to the use of innovation models.

The synopsis of King's (1990) analysis based on sources from organisational and social psychology is presented with references to writings from the educational field. Two levels of research are described, individual and organisational, each subdivided into two groupings - studies of antecedent factors affecting innovation, and process studies.

5.4.3 Individual innovation

Antecedent factors research

A number of variables correlating with innovation or creativity are identified:

- discretion or freedom of choice;
- facilitative leadership styles;

- feedback and recognition;
- nonhierarchical non-rigid organisational structure.

In addition, Lovelace (1986) and Amabile (1983) suggested that a powerful determinant of success can be an individual's motivation.

It is interesting to note the considerable overlap between the variables in the above-mentioned studies and the factors promoting adult learning and motivation for learning, as described in the section on learning. This link is understandable. Overtly, innovation appears to represent a change in the external world. However, in the work-place, it requires an internal change, within the participants in learning. They need to accept new ideas and adopt new ways of working before innovation becomes embedded.

Process studies

Most conceptualisations of the process of individual innovation include the above-mentioned factors. Of interest is Hultman and Hörberg's (1995) review of the research on teachers' utilisation of research knowledge. They identified obstacles to innovation in the implementation phase. Factors included:

- working context (organisational structure and context) that influences attitudes;
- teachers' thought processes i.e. their subjective constructs of the world;
- theoretical knowledge that needs to be incorporated/ translated to a practical dimension relevant to a given teaching situation;
- educational culture and teachers' strategies;
- their individual characteristics as innovators, namely experience, gain/loss perception, and available support.

5.4.4 Organisational innovation

Antecedent factor research

King (1990) (p29) noted three groups of factors: characteristics and behaviour of members in an organisation, characteristics of the organisation, and extra-organisation factors.

In the first group (organisation members' characteristics) facilitating factors are:

- leadership characteristics, namely
 - motivation,
 - values,
 - educational level,
 - management style,
- change agents' characteristics, namely
 - style,
 - interpersonal skills,
 - client-centred behaviour.

Resistance to innovation within an organisation can be due to:

- individual traits such as perception blocks, low tolerance of change, habit;
- social factors (Bedeian, 1980) such as vested interests, rejection of outsiders, misunderstanding, an organisational structure incompatible with innovation and lack of top level support.

The research into organisational characteristics produced a large number of variables. Variables such as organisational strategy, culture and climate are attracting a growing number of studies. An example of the difficulty in applying in the work-place the skills, insights and personal characteristics developed during IPE is cited by James (1994). Obstacles included lack of support from colleagues and management. The central reasons appear to be a perceived threat to the nursing culture, since the impact of IPE challenged established boundaries, roles and professional norms.

The last group (extra-organisational factors) deals with environmental variables. Despite an intuitive feel for the importance of these factors, little consistency in empirical research has been reported. Nevertheless, in the case of IPE within the context of the NHS changes, these issues may be important to address.

In the education field the list of antecedent factors proposed by key writers (Berg & Ostergren, 1977; Mathias & Rutherford, 1983) is similar to the one articulated above. It also includes the foreground issues of the ideology behind innovation, the need for ownership both at individual and organisational level and the gain/ loss perspective (i.e. the material and psychological effects of innovation).

Process studies

Two major stages are common to the process models of organisational innovation - essentially they are initiation and implementation, based on Zaltman et al (1973) and Rogers (1983). Initiation consists of identifying a need, specifying a need and decision-making - that is, choice of a solution. The start of the process can be internal, due to performance gaps or 'opportunistic screening' for innovation, or external, such as legislation. Implementation moves from an initial adoption to full integration or routinisation. Interestingly enough, King (1990) pointed out that this model in common with other process models has not been 'formally tested' (p41).

5.4.5 Social models of managing the dissemination

The models of managing the diffusion of innovation described relate closely to the process models outlined above and are concerned with how the process is managed.

Analysts of innovation in education propose two principal groups of models - in one it is the centre which initiates change, in the second change is fuelled by the needs of the user. The same processes apply whether the centre is national, or the central group within an institution. Schön (1971) proposed three models: the Centre-Periphery, the Proliferation of Centres and the Shifting Centres model. The Centre-Periphery model describes the traditional approach taken by central organs developing policies and expecting these to be adopted by workers on the periphery. Its failure in many instances led to the development of an alternative strategy (Proliferation of Centres) using peripheral, local centres capable of translating a central intention to reality through being closer to the target audience. Both models assume planning for change that arises from a centrally identified need, requiring central support in terms of resources and training. The Shifting Centres model describes a situation of innovation arising 'spontaneously' without central directive, in response to a locally perceived need. The Centre-Periphery model may be exemplified by the introduction of the NHS and Community Care reforms with all its attendant problems due to imposition of new working practices, such as purchaser-provider split or Community Care reforms (see Chapter Two). This model has been successful for IPE in the case of HEA Primary Care Workshops, but an important element has been the voluntary participation of teams.

It is noteworthy that even if careful attention is paid to the dissemination of innovation from the centre by using a more participative model such as the Proliferation of Centres model, implementation can encounter many difficulties if the individual or organisational issues as outlined above are not taken into account.

Van Vught (1989) outlined the relationship between governmental strategies and innovation in HE. He noted that the focus on quantity rather than quality, and on efficiency as opposed to job satisfaction, are counterproductive to the introduction of organisational change. Van Vught concluded, in line with Becher and Kogan (1992), that centrally initiated policies can succeed only if they are in agreement with the philosophy of practitioners and if they are negotiated.

5.4.6 Adoption of innovation

What are the other features of innovation that predict its success and what are the potential outcomes of innovation?

Damanpour (1990) suggested a number of variables related to the perception of decision-makers that might affect the rate of adoption of an innovation:

- type - technological innovation is seen as more effective than administrative, even if in actuality the difference in effectiveness between the types is reversed or even nil,
- the perceived effectiveness of an innovation, even if in actuality there is a lack of correlation between the effectiveness and adoption rate,
- organisational performance or degree of performance gap.

The influence of perception about the innovation is more likely to be dominant during initiation, the decision-making stage. Communication between initiators (managers) and adopters (employees) is seen as crucial to the success of adoption.

Levine (1980), focussing on routinising the implementation stage of innovation in HE, identified four outcomes: diffusion (full acceptance), enclaving (adoption by an isolated unit), re-socialisation (the adopting unit is made to revert to the accepted status quo) and termination (the rejection of innovation). He suggested that compatibility (with values and needs) and perceived or real profitability are the key determinants of the type of outcome.

Comment

Innovation theories appear to offer a useful set of tools for an analysis of change in the education and welfare services. Whilst in most cases they do not look at the policy process, they provide a

human dimension to the consideration of these changes. They facilitate understanding of how individuals, their motivation and characteristics, can influence the fate of innovation both at the individual and organisational level.

5.5 ADULT LEARNING THEORIES

Much of the discussion in Chapter Four that looked at CPD and IPE is underpinned by theories of adult learning. The concept of an adult learner influenced the presentation of issues such as the uniqueness of professional knowledge or how individuals learn in groups. The critical appraisal of the efforts to establish IPE, of specifying relevant learning outcomes or evaluating them, was informed by adult learning theories. Many of these themes emerged during the data analysis.

This section looks at three broad issues - the principal components of an adult learning framework, approaches to a learning needs assessment, and a critique of these ideas from a postmodern perspective.

5.5.1 Adult learning - a conceptual framework

What is the place of adult learning theories in professional education? What are the key features that define an adult learner?

The concept of an adult learner is highly relevant to the field of CPD and IPE. Professionals by the nature of their work have considerable autonomy of action and need to rely on their judgment to manage the diverse challenges posed by their work. Competent professionals use a reflective approach to analyse situations, and are able to discriminate between the need for a routine response or on-the-spot experimentation. This experimentation, labelled by Schön as 'reflection-in-action' (Schön, 1983) allows professionals to deal with the unexpected when previously acquired knowledge is inadequate.

The self-aware and self-directing professional will display these characteristics in their approach to CPE. Bines (1992b) suggested (p59):

A particular significant characteristic of such approaches to adult learning ... is their close correlation to concerns and practices of professionalism and professional education, including, for example, the importance of self-reliance, autonomy and problem-solving in the professional role and the focus in education on enquiry, experience and competence.

The principal features of adult learning

Knox (1973), Knowles (1990 a, b) and Brookfield (1986) elucidated the key components of adult learning theories. They are the approaches to teaching or external context of learning, the background of a learner and the internal characteristics of the learner.

The external context of learning. Respect for an autonomous, self-directed learner needs to permeate the external environment within which learning and its application takes place. All the relevant personnel involved in the learning process will need to acknowledge the individual's learning needs and learning styles. This applies equally to employers, teachers or facilitators of learning and colleagues. While this is important at all stages of professional education, an appropriate supportive climate for learning needs to be present particularly at the CPD stage to allow an easy link between learning and its application.

Background of the learner. All the participants in the learning process need to take into account the individuality of the learners. Thus, their previous educational and professional experiences shape not only the specific learning needs (see later) but also their internal personal characteristics.

Internal characteristics of a learner. Both the physiological and psychological features of a learner (Pennington, Allan & Green, 1984) need to be considered by the facilitators of learning. As a learner becomes older it may be more difficult to acquire new facts and learn new skills, including new learning skills themselves.

The psychological elements determining successful learning outcomes include motivation to learn, readiness to learn and learning strategies and styles. Readiness to learn relates to the triggers for the desire to learn. This will take into account the demands of the external environment, the reality of the development of the professional role and the internal desire to change and progress.

5.5.2 Assessing learning needs

As noted before in Chapter Four, a professional's store of knowledge evolves in an organic and developing manner. In addition to the codified set of facts propounded by the academic community, a very personal set of experiences is built up over the period of a professional life. This has profound implications for CPE as individual learning needs have to be assessed appropriately to achieve relevant and positive learning outcomes, both for the individual and the organisation.

What are the different conceptualisations of the learning needs assessment approaches? What problems can occur if tensions between such different views surface?

One way of looking at this area is to transpose into education Bradshaw's (1972) categories of need, with two key contrasting perspectives. A normative need reflects the opinion of an expert (Nutter & Adkinson, 1989), educator or manager (Graham & Mihal, 1986). Taking this route to assess learning needs is potentially counterproductive if a learner feels pressurised to accept such a definition.

On the other hand, a felt and expressed need represents the professional's subjective perception of a deficiency to be remedied. This approach (of the learner following a personal need) can be seen by management as wasteful of resources, if organisational needs are ignored in the process (see for example Chapter Seven). However, learner-identified needs are more likely to lead to meaningful learning. This can be seen in the case of informal learning projects (Schön, 1987; Gear, McIntosh & Squires, 1994) where the stimuli for learning were the practising professionals uncovering deficiencies in their practice. (See also the analysis of learning need approaches in Chapter Four.)

Comparative need is of particular interest in the context of this study, as it appears only in conditions where the existence of an interprofessional team gives rise to comparisons with other professionals, and where a learning agenda needs to be negotiated by the team's members. In Chapter Four it was suggested as one way of developing learning outcomes for interprofessional teams, starting with the identified problems in teamwork.

Is it possible systematically to approach a learning needs assessment in an organisation? Wright and Geroy (1992) proposed a model of needs assessment for an organisation where, while the goal orientation is primarily on the needs of the organisation, individual needs have to be dovetailed into the overall plan. In such a way not only short-term, reactive needs would be incorporated, but organisational development would be seen as a long-term, strategy-based project linked to the enhancement of its members.. The content of learning would be negotiated to reflect the needs of the learner and the work-place. Note the comment by Knowles (1990 a) acknowledging a tension between the individual and organisation's needs (p17):

One of the pervasive problems in this process is meshing the needs the learners are aware of (felt needs) with the needs their organisation or society has for them (ascribed needs).

This, as seen later in the discussion in Chapters Seven and Eight, presents challenges both for CPD and IPE.

5.5.3 A postmodern critique of adult learning theories

Usher and Edwards (1994) offered a cogent critique of the concept of a self-directed learner. They suggested that, despite its professed acceptance of a human subject as the central concern, humanistic psychology's insistence on scientific method makes it a stablemate of behaviourism. With its commitment to a scientific paradigm it is used successfully to mould human perceptions and behaviour and it 'lends itself more readily to this enterprise since, unlike scientific psychology, it is more effectively harnessed to that other grand narrative, the maximisation of happiness and spiritual well-being' (p44).

The student-centred educational movement has profound implications. The authors identified a search for effective educational production which has as its underlying philosophy a professed democratic sharing of power. By overtly shifting the responsibility for learning to the individual yet denying the possibility of social change, its normative message is conformist and essentially pacifying.

Comment

Adult learning theories play a twofold role in this thesis. They are normative (in the poststructuralist view), in that they suggest which approaches are likely to be useful for professionals engaged in CPD and IPE. In addition, they offer a template for the analysis of empirical data by identifying where such ideals are achieved or not.

In analysing the intentions behind methods that foreground the learner, a contribution is made by the postmodern perspective on the concept of adult learning. Together with a further theoretical framework that builds on Foucault's ideas (see below) it provides a different, more cautious, interpretation of the CPD and IPE field.

5.6 POWER AND DISCOURSE - THE POSTSTRUCTURALIST PERSPECTIVE

Poststructuralism as an analytical approach provides an insight into changes in discourse and the cultural meanings that accompany changes in social policies (Penna & O'Brien, 1996). It helps to account for the development of social policy where diverse interpretations of different experiences

in different settings need to be accommodated. Thus, we see the emergence and interaction of different languages or discourses. This has provided the basis for understanding the different discourses present in key stakeholder groups and the interaction between these (see Chapter Eight).

Penna and O'Brien (1996) noted that (p54):

Poststructuralist work shows how 'social problems' (the object of social policy) are part of much wider discourses, such that political struggles for welfare occur in many different sites: in the social and cultural relations of sexuality, gender, 'race' and ethnicity and age.

There is a need to situate IPE and CPD within these changes of discourse on the role and function of education in a postmodern world.

I make a recourse to Foucault to look at the interactions between the discourses and power within the subject area of my thesis, the health service and professional education. He is useful in this regard as he questions, through his project of analysing modern institutions, some of the fundamental assumptions underlying these institutions - namely humanistic notions of progress and the view of human behaviour as rational. The concepts raised by Foucault - of discourses, power, power-knowledge, surveillance, examination, confession - constitute the building blocks for analysis of the data. This is offered as an alternative perspective to an understanding of the policy process and issues of power within the network of professional education. While Foucault attracts considerable criticism (and some of this is mentioned) his framework is sufficiently comprehensive to throw additional light on the issues under investigation.

The role of education

The first challenge to the accepted role of societal institutions takes as its starting point a particular view of the role of the educational system within the state. As Usher and Edwards (1994) noted, notions of power are central to governance in modern society, but this power differs from a pre-modern approach in that it is 'hidden within modern discourses' (p84). Education becomes a means of governing society. It is not liberating as humanist would have us believe, but forms part of a regulatory mechanism. Transmission of knowledge allows an incorporation of the dominant discourse, and facilitates self-governance by incorporating rules of obedience and discipline.

While those writing on Foucault's relevance to the education system refer to schools (Ball, 1990 a; Ball, 1994), I would like to suggest that such an analysis is relevant to professional education

as well. Why? In school the goal is to instill basic knowledge, skills and moral values. For professional education, it is to convert raw recruits into fully-fledged members of the profession. The question is for whose benefit? And how overt are these goals? I want to propose that professional education, just like the system of compulsory schooling, is concerned with the production of cohorts of individuals shaped to perform the necessary governing tasks of the state. These intentions are hidden, as the professions are under the illusion that they retain a sufficient degree of freedom of action and decision-making. Whilst this view may appear to suggest that learners are passive participants, through the effect of discourses they are in actuality willingly subscribing to societal needs.

The section that follows looks at these issues in greater detail, and the later discussion (Chapters Seven and Eight) grounds them in the actual results.

5.6.1 The role of discourses

This section builds on the ideas contained in Foucault's work, *The Archeology of Knowledge* (Foucault, 1972), where he addresses the role and function of discourses. As Fairclough (1992) noted, discourses actively constitute society as 'objects of knowledge, social subjects and forms of 'self', social relationships, and conceptual frameworks' (p39). They also define how the elements in society interact, and the rules of engagement.

Discourses are mainly hidden, as they appear to be an accepted part of the culture. They can be seen as locally created and specific to a particular setting, group or organisation and they define its culture and language, with power expressed through apparent truth. Truth in this instance is an interpretation of the social reality, which becomes accepted by the targets of discourse. Power then is implied in the adoption of the conceptual framework contained within the discourse, that changes thinking and behaviour. Power is not coercive, but is a corollary of the shared set of meanings.

It is worth noting that Foucault in his original formulation of the discourse gave it a quasi-structuralist twist by according the discourse autonomy and primacy over social practices. He himself changed his mind and moved more towards the poststructuralist position in *Discipline and Punish* (Foucault, 1979a). As Hoy (1986) noted (p5):

Discipline and Punish surprised many because it seemed to be admitting that discourse did not constitute social reality. Instead, discursive knowledge is shown to be produced in the service of an expanding social power that increasingly penetrates modern institutions like prisons, armies, schools and factories.

The constitution of objects (such as the concept of a professional) happens in a continuous transformation of meanings that is defined by the relations of social elements, such as norms, economic background, behaviours, and institutional character. To understand this process there is a need to study the interplay between discourses, in say an institution, or in the field of professional education.

Discourse and education

What is the status of discourse in education? It was suggested above that education is a part of state governance - and discourse here can have two roles. The first is to transmit through the educational system a framework of thinking and conceptualisation deemed centrally suitable for a modern society. The process of constituting the subjects begins to be clear. This does not of course exclude a degree of independence of the educational system itself. As Ball (1990 a) said (p3):

Educational sites are subject to discourse but are also centrally involved in the propagation and selective dissemination of discourses, the 'social appropriation' of discourses. Educational institutions control the access of individuals to various kinds of discourse.

The second role is more reflective of how the educational system is itself moulded or governed through discourse. An example of the potency of discourse is illustrated by Ball who identified the 'discourse of derision' (Ball, 1990 b). This has been used by the New Right to introduce a notion of accountability to curtail the professional autonomy of teachers, in an age where managerialism and consumerism are considered to be defining forces. The professional imperative is considered within such discourse suspect and not conducive to the effective running of services.

5.6.2 The concept of discipline, disciplinary power and bio-power

Here I draw on further seminal works of Foucault: *Discipline and Punish* (Foucault, 1979a) and *History of Sexuality* (Foucault, 1979b). In these works were consolidated a number of key ideas that are used in my analysis, namely discipline, confession, examination and docile bodies. The view on the relationship between the discourses and social practices undergoes changes, as noted above.

The focus shifts: power enters consideration of its functions in relation to discourse, both forming it and being formed by it. The key characteristic of power in modern society is that it is by and large hidden, and is internalised by the subjects. In fact, according to Foucault, it has arisen from

below, building on the techniques of interview and examination. Control over the discourse defining truth, and the boundary between the discourses (and implicitly order of preference or dominance) is fought in a political arena.

Foucault identifies two principal discursive control mechanisms (or techniques of power) - discipline and confession. Their intention is gain control over individuals and over their bodies, to produce 'docile bodies'. (Foucault, 1979a). 'A body is docile that may be subjected, used, transformed and improved' (p136), and 'Discipline increases the forces of the body (in economic terms of utility) and diminishes the same (in political terms of obedience)' (p138). This is the kernel of the argument. The purpose of gaining control over the subjects is to make them more pliable, more amenable to the direction of the state, in order to make them productive, efficient and unquestioning.

Discipline manifests itself in structuring buildings, the working day, the functioning of the body and testing individuals against norms, with punishment if these are not achieved. There are two conceptualisations of power which are complementary. Bio-power (Foucault, 1979b) represents techniques of control over the individual body - over the functions of the body, and over the psyche. Corresponding techniques (described below) are physical examination and confession. Disciplinary power (Foucault, 1979a) refers to behaviour, spacial and social control of individuals. Here belong the techniques of school examination, organisation of space and surveillance.

The expression of disciplinary power in organisational terms can be seen in the modern rhetoric of accountability, a need for ever more detailed management information, financial and clinical audit, and the rhetoric of quality - where on the surface responsibility is devolved down but performance targets need to be achieved as specified from above.

Examination is a central technique of discipline. It extracts knowledge about those being examined in order to exercise power over them. Examination here is used in its wider sense - examining knowledge, behaviour or physical characteristics of individuals. Its three features are visibility, archiving or the creation of records, and transforming an individual into a 'case'. Through examination individuals become visible, and identifiable as they are now subjects of constant surveillance and thus become objects. Secondly, the examination results in the collection and production of records, whereby individuals can be classified and norms can be established. In the process, records are used to arrive at generalisations about the examinees so as to produce knowledge about them, their features, achievements and aptitudes in furthering the exercise of

power. Finally, the examination produces an individual as a 'case' - an objective source of knowledge and subject of control. As Foucault argued (1979a) (p191):

The case ... is the individual as he may be described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded etc.

Whereas examination objectifies individuals, the second technique, the confession, subjectifies them. However, this is not a liberating process. It draws their private lives into the public domain, and thus controls, as it is dispensed in a variety of therapeutic and employment settings (such as appraisal) in order to make people more productive. Foucault (1979b) pointed out the apparently paradoxical relationship between confession and power. He argues that it has become accepted that confession is liberating, that it helps in the struggle against oppressive power. This is because confession reaches out to fundamental truths about self and about interaction with others, which ought to give individuals the power to become self-aware, self-determining, and able to combat subjugation. What is not appreciated is that confession reveals, making the inner world accessible to others. It is this external gaze that becomes the controlling mechanism.

Discipline in education

How do these issues manifest themselves in the educational arena?

Educational discourses in modern education use discipline to produce 'docile' bodies which require less direct control, and where that control becomes more internalised. Teamwork and IPE could be seen as the instruments within the 'discourse of derision' and the discourse of management that marginalises the professions (see more detailed exploration of these themes in the discussion in Chapter Seven).

A move towards organised CPD could be interpreted in the same way. From the point of view of adult learning theory the first step would be establishing the learning need. This, however, entails regularly examining the professionals' knowledge and performance against standards and keeping records of this process. In this way professionals are kept under scrutiny and are classified, and in the process they adopt this ideology as their own. As Foucault said (1979a) (p187):

Disciplinary power ... is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. Their visibility assures the hold of the power that is exercised over them.

What impact does this have on professional practice? A unique combination of two sets of docile bodies - professionals and patients - allows the health service to appear to be run more efficiently. For professionals this is manifest in the use of NVQs or other tendencies in professional education that require the spelling out and measuring of their competencies. For patients, it is achieved through an application of an ever-increasing battery of tests that classify them as normal or deviant. This process of 'normalisation' suggests what is acceptable and what needs to be punished, cured or changed. Thus the responsibility shifts to both sets of actors, with the professionals being unwittingly the instruments of the state. Signs are aplenty. Clinical audit, accountability, citizens' charter: power is dislocated through the knowledge ascribed to the bodies that will exercise it. Bodies become self-disciplining, and coercion is not required.

The technique of confession in education is evident in the emphasis on experiential learning in groups. Much of IPE, for example, focusses on inter-relationships. It uses techniques of teambuilding and interpretation of group processes that rely on inducing an understanding of feelings and reactions towards the other professionals in the learning group. This format of confession to one's feelings of dislike, or prejudices, is used on the assumption that such a confession will result in learning. However, this process allows power to be exercised over the participants by subjecting them to a violation of their personal space. As a consequence, the individuals feels a need to address their unmasked deviant thoughts and attitudes, in order to be accepted as members of the team. This pressure to conform might explain the underlying mechanism of resistance to IPE.

5.6.3 Power and knowledge or power-knowledge

Thus we come to consider in more detail the relationship between the value and production of knowledge, and the visibility and location of power. Foucault himself suggested (1980) that power is not a repressive factor in society (p119):

What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression.

The overt locus of power in modern times has moved away from the sovereign, with its expected obligation to higher ideals, whether of religion or duty to a hierarchical feudal entity. The humanistic ethos, with its concern for liberty and self-expression and its valuing of individual life over an ideology, has placed the focus on the individual. Consequently, the need to govern has had

to adopt a different set of approaches (Foucault, 1979b). Power becomes a social construct, it is located within the whole of society and as such is invisible. The transparency of law, of the norms and mechanisms of surveillance, ensure that power appears to be exercised as if it was arising from below. Individuals appear to have more freedom, but feel obliged to comply with the enunciated norms. That is not to assert that there is no struggle, no dialogue of power between what Taylor (1986) (p85) calls: '... the macro-contexts - state, ruling class...' and 'the micro-contexts' i.e. the individuals. Instead, the operative word is dialogue, or more precisely the mutual constituting and shaping of the agenda and responses. This concept of power does not imply a location of power in the ruling elite which controls the population, and its absence in individuals. The power is diffuse: the individuals, whilst shaping it, are simultaneously positioning themselves as its objects.

Power/ knowledge

Another notion which is relevant to this discussion features more prominently in later writings of Foucault - that of a link between power and knowledge. Knowledge in this formulation covers knowledge produced both in scientific endeavour and during the examination process as described above. This section draws on his work *Power/ Knowledge* (Foucault, 1980).

According to Foucault, the humanist view of the relationship between power, truth and knowledge is flawed. An idea has developed in modern times which counterposes power (equated with the state and other governing institutions motivated by the need to coerce) with knowledge and truth. This truth can be obtained only in the spirit of disinterested inquiry, unfettered by external constraints. The modernist view of truth crucially suggests that it is possible to obtain an objective view of the world, unrelated to the personal, social and historical context.

Foucault, however, suggested that truth is relative, and closely tied up with the societal discourses of power (Foucault, 1980) (p 131):

Each society has its regime of truth, its 'general politics' of truth: that is the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true.

This passage is significant, as it delineates the close link between truth and power, between the validity of truth claims and those who define this validity. Truth embedded in knowledge production and dissemination is in fact a servant of society as a whole, of its need to subjugate

individuals through the adoption of the power discourses, that in turn become congruent with these individuals' own wishes. Knowledge does not exist in a vacuum - it only makes sense when it is used, when it is an inseparable part of power. Power, argued Foucault (1979a) (p27):

...produces knowledge ... power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.

Foucault sees the link between the truth and power discourses (Foucault 1980) (p 131):

...truth ... is the object... of immense diffusion and consumption (circulating through apparatuses of education and information whose extent is relatively broad in the social body...); it is produced and transmitted under the control, dominant if not exclusive, of a few great political and economic apparatuses (university, army, writing, media); ...

The link between power and discourses is clear. The use of a particular discourse carries with it an acquiescence and adoption of the claims of that discourse about what is true, and power is thus carried through this process.

Foucault, admittedly, has been accused of dismissing the notion of progress and enlightenment, and of being one-sided in his analyses of the modern condition (Hoy, 1986; Taylor, 1986). His critics suggest that he does not want to take sides, that for example his (Taylor, 1986) (p98): 'monolithic relativism only seems plausible if one takes the outsider's perspective, the view from Sirius...'. However, for the purposes of this work I take his insights as providing a very useful lens for dividing the light of the modern welfare state and professional education into its component bands of colour.

Power/knowledge and education

What then are the implications of these concepts for the role of education?

Human science power-knowledge formations, wielding 'discipline-validated truth', exercise power through classification and regulation, dividing subjects by behaviour and characteristics into opposing groups - good and bad, normal and abnormal. Knowledge becomes a tool of control, the more so as the concepts of truth and knowledge become synonymous. Power-knowledge discourses circumscribe truth and its manifestations, and provide rules for testing knowledge for the validity

of truth claims. The educational system, according to Foucault, plays a crucial role in creating, validating and transmitting knowledge as an integral part of the state apparatus.

It is here that the discursive practices of power are manifest through surveillance, confession and examination, as discussed above. Familiarity with these techniques of power is carried within all the subjects from that time onwards, making them open to such practices in later life, both at work and in their personal/ social space. Two kinds of knowledge are created in the educational system. The first is created by the individual - knowledge of self - and it incorporates the classification of self according to the norms. The second, held by the system, is the accumulation of items of knowledge about individuals, their allocation to different types of categories, and the accumulation of experience of effective methods of controlling these 'docile bodies'. The performance of learners, their individual differences in achieving progress, becomes a substrate for study, for the production of knowledge used for predicting their success. The educational establishment becomes a producer of knowledge during the study of an individual as an object, and that in turn allows a greater and more subtle exercise of power over the individual as a subject.

Secondly, the education system has adopted (Usher & Edwards, 1994) the disciplinary discourses of psychology and sociology for the overt aims of improving the understanding of individual needs, of making education more sensitive to learners' development. Thus one can begin to trace a movement away from didactic teaching to an encouragement of active learning. However, the underlying rationale is still the production of effective citizens.

Power-knowledge formations define the parameters of what is acceptable and mould educational practices predominantly in a hidden way. This is the true 'hidden' curriculum, the brainwashing or socialisation of the learner to a societal network. Not surprisingly within this interpretation, student-centeredness coincides with a greater pressure on individuals to equip themselves to be flexible, and to have a range of desirable skills for a changing environment.

5.6.4 Resistance to power

Social organisations are permeated by multiple discourses. Embedded within these discourses are inconsistencies. These inconsistencies create an opportunity to resist the impact of power. Power and resistance are intimately linked: as the power is constituted and expressed, resistance to it arises, and this resistance in turn modifies the power. Foucault, however, argued (1979b) (p95) that '...there is no single locus of great Refusal, no soul of revolt, source of all rebellion, or pure laws

6 CHAPTER SIX - METHODOLOGY

6.1 INTRODUCTION

In this chapter I outline the methodological framework used within this research. An introduction to the key theoretical issues is followed by an enumeration of the sources of the data and the associated methodological aspects. I then focus on describing the theoretical and methodological foundations of the two principal analytical approaches, namely 'grounded theory' method and discourse analysis.

6.2 THEORETICAL NOTE

This section outlines my arguments for using qualitative data collection and analytical methods, describes the principal underlying theoretical framework (i.e. ethnography) and locates the use of different types of triangulation in my work.

The methods chosen for the data collection and data analysis fall within the qualitative research paradigm, and follow broadly the ethnographic tradition (see below). I would like to argue that using, however modified, ethnographic data collection methods, namely participant observation and interviews with the relevant subjects, and the data analysis methods that include 'grounded theory' method and discourse analysis, is legitimate within this tradition. They were chosen as they are methodologically congruent with the aims and objectives of this research (Powney & Watts, 1987), namely 'grounded theory' method relates to Objective Three and discourse analysis to Objective Four (see below). The limitations and modifications are touched on later.

3. To critically evaluate the emerging picture of IPE and CPD and their relevant contexts on the basis of this theoretical framework. (This framework was developed and described in Chapter Five).
4. To investigate how IPE and CPD feature in the thinking and practice of key players who are identified as policy makers, educators, employers, and the professionals themselves.

Why have I chosen qualitative research methods? The field of CPD and IPE is relatively underresearched and more specifically the links between various context factors and CPD and IPE lack sufficient evidential and theoretical basis. Consequently, it is necessary to map these links as they are seen by the key stakeholders. Thus, as I will emphasise again later, this work is not a

of the revolutionary.' Instead resistance just like power is pervasive through the social body (p96):
'... the swarm of points of resistance traverses social stratification and individual unities.'

Each discourse will define and highlight alternative discourses that may contain a kernel of resistance to that particular discourse. And yet they are dependent on each other for constant redefinition of their positions and of how they position the subjects.

Power, and resistance to it, are diffused through the system of the exercise of power. Educational practices are expressions of that power control, and educational institutions are designed to operationalise this exercise of power. The paradox is inherent in how power is expressed - the individual is encouraged through the discourse of adult learning to be self-determining. However, this position is not an absolute one, but relative, defined by this and other discourses which circumscribe the limits of freedom. Resistance is possible, but it only redefines the expression of power, it does not remove it.

5.7 SUMMARY

This chapter has outlined the two groups of theories I have chosen for the data analysis. In the discussion chapters (Chapters Seven and Eight) both groups, in most instances, are used to look at the same set of results to obtain a wider understanding of the issues. In addition, Foucault's concepts contribute to the building up of the discourse analysis method presented in the next chapter. The analytical process will address critiques levelled at these theories, whilst gauging their value.

survey, but an in-depth exploratory work, that results in a depiction of this fast changing area. An ethnographic approach is eminently suitable for this purpose, as it starts with the individuals and their interpretations of the social world they inhabit. As Miles and Huberman (1994) (p10) mention, qualitative data are useful as they are grounded in actual situations or perceptions, their richness can reveal the complexity of phenomena studied, the researcher can uncover meanings given to these phenomena, and it is possible to assess links between them and even to postulate causal chains. All of these considerations are important in my work.

The direction of the research

The pragmatic approach that I have taken here is congruent with the qualitative research tradition, where a rigid application of methods is not the mainstay of the thinking. The artistry of qualitative research allows for a variation of classical ethnographic methods to be used with, of course, an adequate justification put forward for varying the classic canon. This is not true for the positivist tradition where much stricter demands are put on the researcher (Cohen, Manion, & Morrison , 2000). First of all, a positivist researcher starts with a hypothesis derived from a theory. This hypothesis is then tested through quantitative data collection methods, which might be experimental in design. Results will be numerical, to provide an answer to questions such as: how much, to what extent or what is the specific contribution of different factors to final outcome.

I do not propose to enter into a further debate on positivist and interpretationist positions in social sciences at this stage. This has not been relevant to the selection of my data collection methods as no quantitative or quantifiable data were collected. A tension between those two positions, however, is revisited later in the discussion (Chapters Seven and Eight) as the two principal theoretical groups of perspectives employed, namely those coming from the positivist stable (on power, policy-making, innovation and adult learning) and poststructuralist theory, represent different underlying views of the social world.

The use of theories from two different orientations could be seen to stretch further the boundaries, however flexible they are already, of the ethnography. I do not believe this to be the case. The pragmatism, the artistry, the contingent approach of the research and the nature of the subject matter seems to me to suggest that multiple voices and perspectives cannot but enhance the understanding of it. I will argue later that this approach is a theoretical triangulation (Denzin, 1970). In the meantime I can call on Atkinson and Hammersley (1994) who state that ethnography has moved in recent years from being a purely academic to a more practice involved discipline,

where the researcher makes an effort to interact with the research subjects and to participate in the change process itself. This, in the end, is the intention of this work.

6.2.1 Why ethnography? And what kind of ethnography?

Why have I decided to use the label of ethnography to describe and justify my research methodology? The close involvement with the field of the study, the employment of open-ended interviews and participant observation are the methodological hallmarks of ethnography. Further, attempts to understand the context, the relationships and the meanings assigned to aspects of professional life and the learning of the key actors, represent the ethnographer's interest in perceiving the world through the eyes of the research subjects. I do not profess to adopt a particular stance within the broad church of ethnography.

Origins of ethnography - Blumer and the Chicago sociology

Hammersley (1989) traced the history of the Chicago sociology that used ethnographic methods (originally developed by the cultural anthropologists) to study contemporary society. Symbolic interactionism has been identified as the descriptive term for the theoretical and methodological foundation of this school. Its principles are reflected in my work: the interest in uncovering the meanings attributed by the social actors to their world, and how these meanings influence their behaviour and interactions.

Hammersley (1989) went on to analyse Blumer's (an eminent member of the Chicago Department of sociology) writings. Blumer critiqued the positivists' assumptions that it is possible to achieve an objective view of the social world, and that it is possible to create firm representations of social phenomena. He argued that any conceptualisation of the elements of the social world is fraught with difficulties, as these have unique rather than common features that characterise the natural world. His description of symbolic interactionism is apposite for this work, as he noted that human beings interact through agreement on the symbolic significance of words and actions (Blumer, 1966) (p540) (as cited in Hammersley (1989), p130):

This world is socially produced in that the meanings are fabricated through the process of social interaction. Thus, different groups come to develop different worlds - and these worlds change as the objects that compose them change in meanings.

This motive appears in my analysis - the differing perceptions of the context, i.e. the NHS changes, are created in the interactions within a particular stakeholder group and have implications for the

work of its members and their approach to professional education. In addition, the perspectives of the stakeholders, and how they regard each other, inevitably influences their interaction.

The ethnographic method used by the symbolic interactionists relies on so-called 'naturalistic method' - not to be confused with methods used in natural sciences. In contrast to these, it starts with the nature of the phenomenon and employs methods (such as detailed observations and comparisons) that are congruent with it, and that are capable of closely capturing its inner richness.

Problems in qualitative research

Hammersley (1989) proceeded to analyse the dilemmas inherent in qualitative research as conceptualised by Blumer.

Blumer suggested that the hypothetico-deductive method (used in natural sciences) is not applicable to the social world as it does not allow for the challenging of all the underlying assumptions. Hammersley on the other hand argued that we need to rely on some assumptions as it is not possible to test an infinite number of hypotheses.

According to Hammersley, Blumer underestimated the difficulties involved in the research where the measurement interferes with the measured. For Blumer, this was one of the hallmarks of the scientific method where objective measurements of the physical world could be obtained.

In conclusion, naturalistic research does not meet Blumer's criteria for science, as it is not possible to apply the hypothetic-deductive method to the social world. Problems arise in trying to specify a definite conceptual base for social phenomena and observers influence the observations.

Alternative solutions to the dilemma of qualitative research?

Hammersley proceeded to explore possible answers.

Is it possible to uncover cause and effect in the social world by direct perception? Is it possible to test it? This is more difficult with social phenomena. Are we just observing regularities in patterns? Asking participants means that the social actors may give a false perception that they are aware of the complex set of factors that influence their actions and decisions.

Hammersley suggested that the hypothetico-deductive method complements the (commonsense) pattern approach in qualitative research. The pattern model (Hammersley, 1989) (p204) appears to be closer to the 'real world' in that it tries to describe and explain the social world densely.

These two methods are reflected in my work by use of the two groups of theories outlined in Chapter Five. The theories from the positivist stable (on power and policy-making, innovation and adult learning) suggest that it is possible to see the relationship between phenomena in the social world, and the actions of the stakeholders and their context. On the other hand the discourses prevalent in the stakeholder groups represent the patterns of thinking and behaviour consistent with their perceptions of the social world they inhabit.

Blumer, in Hammersley's view, neglected the role of motivation and the role of macro factors on human actions. Similarly, he dismissed the role (of what could be seen as a structuralist interpretation) of the impact of culture and developed social patterns of behaviour on human action. Instead, he postulated that there is in fact complete freedom to create the meanings without any precedent.

In summary, Hammersley concluded there is a need to work on both fronts - neither the sciences or symbolic interactionism provide a complete answer to the dilemma of qualitative research.

6.2.2 Triangulation

The concept of triangulation in social research was developed by Denzin (1970). He originally postulated four types of triangulation:

1. Data triangulation: where different types of data are used (strictly speaking 'time', 'person' and 'space' triangulations mentioned below, according to Denzin, belong here; however, for the purposes of this discussion I have separated these);
2. Investigator triangulation: when different researchers address the same area under investigation;
3. Theory triangulation: where different theoretical perspectives are employed to look at the same data;
4. Methodological triangulation: different research methods, such as qualitative and quantitative, are used. This approach is traditionally understood to represent triangulation for the purposes of validation of results (Begley, 1996).

Other types have been identified as well (Denzin, 1970; Janesick, 1994; Cohen, Manion et. al., 2000). These are:

5. Time triangulation: in essence these are cross-sectional and longitudinal studies;
6. Space triangulation: helps to obtain a more complex picture of the same phenomenon in different cultures;
7. Person triangulation: where different groups of people might be compared, or contrariwise an aggregate picture might be sought;
8. Combined level triangulation: used in the same organisation to combine analysis of its different levels (i.e. individual, team and the whole system);
9. Interdisciplinary triangulation: by using different academic disciplines.

The purpose of using triangulation is to achieve a number of possible objectives. Two principal advantages are: obtaining a richer picture, as the same phenomenon is observed from different angles, such as by using different data or investigators; and being able to identify different issues, for example by using different research methods or theories. Silverman (1985), however, argued that triangulation falls into the positivist tradition, as it implies that there is a knowable reality that can be uncovered by using appropriate methods. However, I would like to suggest that both positivist and subjectivist paradigms can be served by triangulation. I will be using it in this work in three formats - in regard to data sources, persons and theoretical interpretation of the findings. To re-iterate, my purpose is to obtain a rich picture of the area, which any one type of data could not provide on its own. I will interrogate the data from individuals in two ways: both as an aggregate and also comparing different stakeholders where relevant. Further, the use of different theoretical paradigms serves two ends - one is indeed to validate the interpretations produced through analysis from a given theoretical perspective and the second, where appropriate, is to offer a contrasting or complementary view of the situation.

6.3 DATA SOURCES

Data for the study come from interviews, participant observation and documentation. These sources were selected to gain a rich descriptive of the area under study, as the interrelationships between the issues and the forces moulding them are complex and fluid. The sources complement each other in that intentions may be expressed in the documentation and some interviews, but their translation to a living reality is better accessed by observing the behaviour and pronouncements of the key people at meetings or during the policy formulation process.

6.3.1 Sampling

What were the guiding principles for sampling in my work? As alluded to above, I did not embark on a survey of opinions or attitudes, but rather was interested in mapping the perceptions and forces acting in the field of CPD and IPE. The key question then is: what sources can provide, to best of my knowledge, relevant information, insights or access to thinking of key stakeholders?

Sample size and sampling strategy

In qualitative, interpretive research the sample does not need to be large. As Powney and Watts (1987) (p121) said: ‘... the sample should be as small as is consistent with obtaining valid data.’ The other factor determining sample size and strategy is representativeness. The interest here is less in generalisability, and more in identifying representative respondents, locations and documents that can produce data congruent with the research objectives. Thus probability or random sampling was not appropriate for my study. Non-probability, purposive sampling was more relevant (Cohen, Manion & Morrison, 2000). According to these authors (p103): ‘In purposive sampling, researchers handpick the cases to be included in the sample on the basis of their judgment of their typicality.’ In my case I was looking, for example, for individuals in a position of power or responsibility, who are actively involved in shaping CPD and IPE, but typically within different roles, ranging from management to educators.

Another characteristic of my sampling strategy was conceptually-driven sequential sampling (Miles & Huberman, 1994). The exact number and class of sources evolved as the research began to unfold. Some respondents or settings were identified as important once the initial analysis of the early interviews had shown a need to look for an additional or different type of input. Thus for example, in interviewing a GP teacher, a research project looking at the CPD of GPs in one geographical area came up as a topic. I found it useful to interview the actual researcher involved, as the perceptions of a non-medical person provided a required contrast to medical views within the developing picture.

A more detailed consideration informing a choice of sources is presented under each relevant section.

6.3.2 Interviews

Why have I chosen interviews as one of the principal sources of data? And what type of approach to interviewing have I used? What are the advantages and disadvantages of interviews? Do any specific issues arise when considering the subjects chosen for interviews in this work?

Interviews are an excellent method of accessing information, and the views, opinions and attitudes of individuals. They are most appropriate in the stage of research that is exploratory, especially the open-ended or 'interview guide approach' (Cohen, Manion & Morrison, 2000). The other types of interviews, such as 'standardised open-ended' and 'closed quantitative' interviews would be too restrictive in their design. Such interviews are useful in surveys where a more standardised set of questions producing comparable answers are required. For me it was more important to approach each respondent as a unique case within a specific context that had to be explored 'de novo' each time. (See the interview guide (Kvale, 1996) for the list of areas I wished to explore - table 6.1.) I allowed myself and the respondents freedom to roam freely within these topics as I was keen to build up a picture from the ground up. It was important to have that degree of freedom as the roles and functions of the individuals were usually changing, and they themselves were involved in new developments, where the remit of their actions and their meaning had to be defined and redefined continuously. As the interviews progressed and the analysis began to throw up some key issues, a more focussed questioning could be undertaken. This was designed to confirm or deny (or rather extend) the range of meanings or interpretations within the emerging categories.

All the major advantages and disadvantages of this method stem from the interpersonal interaction entailed in such a 'social' encounter (Kvale, 1996). A face-to-face interview provides an opportunity to be flexible, to respond to clues and follow up areas of interest as they arise within each situation. On the

- | | |
|----|---|
| 1. | Area of work, specific professional and managerial responsibilities |
| 2. | The individual's involvement in delivering, facilitating or purchasing professional education with specific focus on CPD and IPE. |
| 3. | The role of their department in CPD and IPE. |
| 4. | Their understanding of the changing context within NHS and Community Care that impacts on their own work, that of their colleagues or other professionals they deal with. |
| 5. | The impact of these changes on CPD and IPE. |
| 6. | Their interactions (on individual and institutional level) with other key players in their work, and specifically in the CPD/ IPE aspect of their work. |

Table 6.1 Interview guide

other hand there is always a possibility that the interviewee might bias the answers to make himself or the organisation appear to be acting in a 'better' light than might be the actual case. The open-ended interviews, as conceptualised here, represent a dialogue between the knowledgeable researcher and the subjects. From the beginning it needs to be made clear, that I as a researcher and practising GP, approached the topic under investigation with some knowledge of the issues and inevitably some bias. I return to the issue of bias later.

The advantage of approaching the subjects with a store of background knowledge was to allow a deeper exploration of issues as they emerged during the interviews. Further, it helped avoiding missing references to important, frequently unexpressed assumptions and practices. I had to be prepared to question, at times naively, the subjects about their actions and relationships which they themselves took for granted. Similarly their perceptions of the changes occurring in the health service and in professional education had to be accessed, as the meanings of these changes differed between the stakeholder groups and frequently, from my own understanding. There were occasions when it was relevant to express my own views or perceptions. This allowed a more open dialogue, a more involved interchange, that moves away, as noted by Fontana and Frey (1994) (p371), from 'outdated' quasi-objective technique to an interview that is 'more honest, morally sound and reliable, because it treats the respondent as an equal'. This obviated another set of potential ethical concerns (Powney & Watts, 1987), such as issues of inequality of power and status or the possibility that information elicited in interviews can be used against the informant.

Methodological concerns

Kogan (1994) poses a number of methodological questions arising in the process of researching the 'powerful in education and elsewhere'. Not all of these issues are relevant to this study, as the interview subjects were predominantly those from the middle ranks of the power elite. Nevertheless, a mention of two of these is appropriate at this stage.

Framing questions

An important observation is made by Kogan. How much should the interview, the obtaining of the data, be guided by a theoretical framework? This is familiar ground to those engaged in qualitative research, and the answer, appears to me to be that a theoretical formulation of research questions is impossible - some underlying theory, even if not acknowledged, is always present. The shape of the underlying theory began to evolve from the beginning of this research through the process of reflection and initial analysis of the interviews. This process followed grounded theory precepts (Strauss & Corbin, 1990) (more on this later). Thus, features representing innovation or power

discourses were elicited or listened to with a much greater degree of clarity as the interview process developed.

Powney and Watts (1987) underline the issue of language or rather of mental frameworks with which both parties enter the interview process. One task of the interviewer is to make sense of the referential framework of the respondent (this is data reduction in action), whilst not trying to impose one's own understanding onto interview. This might not be easy, but is necessary for eliciting the unique set of meanings, the constructs that define the interview subject's life.

Interview bias

I need to question whether considerable bias has entered into my formulation of the questions and interpretation of the data. I am aware that I have posed a hypothesis that the introduction of IPE is part of the trend to diminish professional power. Even if I profess to be committed to IPE, inevitably as a health care professional, a member of a powerful elite of doctors, I may feel threatened in the long run by these educational initiatives. Does this mean that I have selectively collected and interpreted the data to fulfil this perception?

Interview subjects

Twenty-four stakeholders were interviewed initially - see Table 6.2.

The interviewees were chosen to obtain a spread of perspectives from local, regional and national levels. The intent was to gain a composite picture of interlocking influences and interests within the whole health care and associated educational systems. These interviews were done between January 1995 and January 1997. The sampling strategy as described before was non-probability purposive. I have been able to identify from my knowledge of the field and through discussion with other key figures in professional education who might be the representative people that would fit specific categories required. As can be seen from the table, I was interested to access people in diverse settings - GP practices, trusts, education establishments, and those with regional and national perspectives on CPD and IPE. Gaining access to these interview subjects did not prove to be problematic and they participated fully in the interview process. The only technical problem that appeared was the failure of the tape recorder on three occasions. In two of these cases I had to rely on my field notes and in the third, unfortunately, records were lost. A detailed list of the subjects and their background and roles is in the Table 6.2.

The interviews lasted between one and one and a half hours and were recorded and transcribed.

identifiers	professional background	educational role	management role
nurse education advisor 1	nurse	educational manager/ purchaser	for health authority
nurse education advisor 2	nurse	educational manager/ purchaser	for trust
nurse education advisor 3	nurse	educational manager	health authority/ region
nurse educator 1	nurse	education manager	team / unit manager
nurse educator 2	nurse	professor of nursing	university department head
UKCC person/ professional body officer 1	nurse	UKCC deputy manager	national
Midwife educator	midwife	educational manager/ tutor	for trust
GP educator 1	GP	educational manager	associate dean - regional role
GP educator 2	GP	facilitator; member of SCOPME IPE/ teamwork group	medical politics - local and national
GP educator 3	GP	educational manager	associate dean - regional role
GP educator 4	sociology	CME	none
medical education manager 1	medic	educational manager	regional education manager
medical education manager 2/ professional body officer 2	GP	educational manager/ purchaser	regional and national
medical education advisor	medic	secretary SCOPME IPE/ teamwork group	national
health authority manager	medic	education purchaser	primary care manager/

identifiers	professional background	educational role	management role
lay person		member of SCOPME IPE/ teamwork group	advisory
trust manager 1	manager	advisor/ chair of SCOPME IPE/ teamwork group	trust Chief Exec and national
human resources person	manager	education purchaser	Human resources in trust
team facilitator 1		Primary care team facilitator	in GP practice
team facilitator 2	SW	Community Care/ primary care team facilitator	communication between primary care and social services
team facilitator 3	manager	workshop facilitator	region/ local
primary care researcher	research	university	investigate IPE in locality
educational facilitator	education/ psychology	advisor/ workshop facilitator	district/ resource manager

Table 6.2 Interview subjects

After the initial set of interviews were completed, I felt I needed a few more focussed interviews with people who could throw additional light on some of the issues, such as role of key stakeholders, the state of education purchasing and the status of IPE. This subsequent sample was thus also purposive. These interviews took place in 1997 and 1998. See Table 6.3 for more details.

identifiers	professional background	educational role	management role
education advisor	manager	writer/ advisor	none
nurse education advisor 4	nurse	educational manager/ purchaser	trust

identifiers	professional background	educational role	management role
trust manager 2	manager	educational manager/ purchaser	trust
professional body officer 3	medic	education advisor	national
professional body officer 4	medic	education advisor	national
IPE champion	SW	IPE advisor/ promoter	general manager of advisory/ pressure group - national
medical education manager 3	medic	educational advisor/ purchaser	trust
medical education manager 4	medic	educational advisor/ purchaser	trust

Table 6.3 - Additional interview subjects

6.3.3 Participant observation

Participant observation

Participant observation is one of the principal methods in ethnographic research. It allows the researcher to gain an intimate knowledge of the study area, of the behaviour of the subjects and through direct involvement gives an opportunity for the researcher to gain an insight into the thinking of the other participants (Jorgensen, 1989; Atkinson & Hammersley, 1994). Silverman (1993) warns, however, against a simplistic adoption of the view that the aim is to 'see the world through their eyes'. Wholesale adoption of the observed subjects' perceptions would deny a role to critical interpretation and the attempt to place the findings in the wider context.

A simple dichotomy of non-participant and participant observation is challenged by Atkinson and Hammersley (1994). Traditionally the non-participant observer was held not to take any part in the proceedings being observed, but simply to note the processes, reactions and interactions in a specific setting. Gold (1958) suggested four types on the continuum - complete participant,

participant-as-observer, observer-as- participant and complete observer¹². In my case I have taken, according to the circumstances (see below), one of the two middle roles. This is consonant with observation by Adler and Adler (1994) that currently naturalistic observers favour a more active involvement with their subjects.

Entry to the settings for participant observations

I had an opportunity through my contacts and work within the GP education structure to take an active role in various bodies concerned with professional education. My interest in GP and interprofessional education has made me a welcome member of these groups - I was invited onto some of them, and on others I represented another body, such as the Royal College of GPs. Thus the sampling strategy was a mixture of non-probability convenience (mainly the local and regional settings) and purposive ones (mainly the national settings - see below).

Methodological concerns

To be a participant observer throws up even more challenges in the research process (Bryman, 1989; Silverman, 1993; Adler & Adler, 1994). What is the role of the researcher? To what extent is it possible to collect unbiased data? How much is the process of the observed interchange influenced by the actions of the observer?

It is possible to see that the basic two stances alluded to above (i.e. observer as a participant and participant as observer) were rendered more complex by some of the considerations enumerated by Atkinson and Hammersley (1994) (p 249). In situations where my role as a researcher was known to all the participants, not all of them were fully appraised of the details of my research. How ethical was this? Would they be less likely to be forthcoming in their contributions? I hope not, but I have nevertheless kept the identity of contributors anonymous.

In situations where I was an equal participant and decisions had to be made and agreed, my contributions moulded the outcomes. Some meetings or workshops demanded that I was only a contributor to the discussion, where the exchange of experiences was the primary task, while in

¹² There is a considerable overlap between this topology and that of Adler and Adler (1994), which specifies just three points on the scale: peripheral-member-researcher, active-member-researcher and complete-member-researcher. It can be seen that the 'detached' role of complete observer is absent here.

others a more active role was expected of me. It is difficult to see how I could have behaved in an unbiased way during such proceedings. Of course the question is, to what degree were my contributions decisive? In most cases they were indeed just contributions, rather than a major force in shaping the agenda.

Another element concerns the data collection. What information was I interested in? And what bias might be introduced by the selection implied in this process?

I recorded my comments during each meeting of the key issues raised, the interactions that I thought relevant to my research and my own reactions to the process (Cohen, Manion, & Morrison, 2000). In addition, I frequently made notes of situations that related to manifestations within the terms of the theoretical constructs, such as power, innovation or organisational behaviour. These notes then were transcribed for future analysis. See for example Appendix Three - from one of the meetings of an educational group. Numbers on the side refer to codes allocated by me, and will be returned to later; theoretical comments are in italics. See also Appendix Four - as an example of reflections noted during the transcription process (these reflections are located at the end of my field notes from one of the meetings which are not included here), and how they related to potential theoretical constructs.

Validity can be a problem (Adler & Adler, 1994), as there may not be another source or another observer present capable of confirming the validity of the data. In my case, to confirm that I have not missed or misinterpreted the information, I have triangulated, where possible, my notes with the minutes of the meetings (see later). Silverman (1993) provides a useful checklist for establishing validity of observational data. He advocates, among others, making comparisons between different groups of similar subjects, or in different settings or looking for 'negative or deviant cases' (p 44). As my intention was not to make definitive statements about a particular group, but rather to map the educational system, I have treated each group and setting as instances where the features of the system manifest themselves. Contrast and comparison occurs within this framework.

How did I deal with these challenges? I had to keep a sharp researcher's eye on the events at these meetings and be able to reflect on the process as it was unfolding. The tension is obvious. How is it possible to record the activities, my reactions or immediate interpretations of the action taking place, and yet be an active participant? I need to acknowledge that I am not trying to achieve an objective representation of the reality, and that what I present is my own interpretation of the developments in the system - of meanings and their creation during the participative stage of the

work. Nevertheless, I have tried to listen to other 'voices' in the proceedings, to be sensitive to issues that did not appear to be immediately relevant to my focus of analysis. As Jorgensen (1989) noted (p 82): 'Previous experience and knowledge may be inappropriate, somewhat slanted, or simply incorrect.' I have tried, at least at the beginning of the whole process, and especially in new settings, to observe with a completely open mind and to be prepared to be surprised.

These tensions and discrepancies were important on reflection - they allowed me to guard against one-sided interpretations. Informal discussions after meetings were used at times to check my perceptions of the dynamics and meaning of the key issues, thus contributing to the process of face validity.

Sources of observation data

The data were obtained through a process of participant observation during attendance at the meetings of a variety of bodies and organisations dealing with primary care education, or conferences concerned with a similar range of subjects. The key series of meetings were:

Local or London-wide:

Education Boards: these are concerned with planning and co-ordinating education for GPs. Each health authority has one such board, on which representatives of different stakeholder groups are present. For GP education these cover undergraduate, vocational training and CPE, the Royal College of GPs, regional GP education structure representatives and local GP tutors. Other people present include representatives from the health authority and the local trust. Education boards supported IPE within general practices through the disbursement of funds under the LIZEI scheme (see below) and by encouraging practice development plans. I have drawn on a set of 10 notes for analysis.

The other meetings attended were set up within the organisational structure of the postgraduate department of general practice, which is part of the regional education structure. Participants at these meetings were primarily GP educationalists, namely those concerned with organising vocational GP training and GP tutors responsible for GP CME, and the employees of the postgraduate department who themselves work as GPs. The role and function of these meetings varied - sometime these were policy-making meetings, while others provided a forum to discuss the future plans and changes occurring in the whole system and the impact on GP education. Four sets of notes were used.

Further meetings that I participated in were committees of the health authority concerned with education. The stakeholders varied, but always included GP representatives and health authority personnel. This committee's remit was to advise the health authority on the changing context of professional education and was relevant until the education consortia were established in 1997 (see Chapter Four). From this sets of meetings five sets of notes entered into the analysis.

LIZEI (London Initiative Zone Educational Initiatives): this was a special project financed by the Department of Health for three years between 1995 and 1998 to encourage Inner London GPs to avail themselves of additional educational opportunities. I have participated in a number of policy-making meetings of the committees, charged with the responsibility to roll-out the programme. These ranged from local to London-wide meetings. Representation on most of these groups was from GPs and GP educators only. However, some of the educational boards were more innovative and employed facilitators from other backgrounds who specifically took on a role of promoting IPE in practices on their patch. Four sets of notes were used here.

National:

SCOPME: until recently this was an advisory committee to the Secretary of State for Health on postgraduate education for doctors and dentists¹³. For three years between 1995 and 1998 one of its projects was the investigation of IPE and interprofessional working and I was an observer at the meetings and workshops organised by this working party. Its membership was wide-ranging - it covered influential medical educators, lay people, management people and non-medical educationalists involved in medical education. It worked through obtaining written and oral evidence from professionals, educators, institutions of higher education and Royal Colleges on their attitudes and experiences on the subject of IPE and interprofessional working. Five sets of notes entered the analysis.

CAIPE: this organisation has already been referred to in Chapter Four. Its remit is the promotion of IPE within the UK, and its various committees and regional meetings provided an opportunity to gather information on the views of active players in the IPE field. I have used four sets of notes.

National conferences on CPD, IPE and work-based learning were valuable, as besides some set presentations, there was a much richer source of data in the various workshops where a mixture of professionals, educationalists and policy makers participated in lively exchanges. There were seven such conferences that provided data for my field notes.

¹³ It was wound up in early 1999

Methodology note

The observations took place between 1995 and 1998.

As with the interviews, the observations started fairly unfocussed. As the key categories became clearer over time, I began to pay more attention to these, whilst keeping an eye open for conflicting dimensions or for new categories or issues (Adler & Adler, 1994).

As with interviews, my field notes were transcribed. The documents (see below), if not available in electronic form, were scanned.

6.3.4 Documentary analysis

I decided early on that it would be necessary to triangulate the information from the interviews and the observations, by using documentary sources to obtain a wider perspective on the issues of policy development and implementation. A more immediate triangulation of the observation data was achieved by the use of minutes of the meetings I attended. While in some cases the discrepancies between the two accounts, or the differences in a focus of attention were minor, in others there were substantial disagreements. This was a useful trigger to reflect on the source of the discrepancy - was it due to my bias or that of the minute taker? Whose view did I need to take as more representative of reality? Of course, this again begs the question of what I mean here by reality. In most cases, I resolved this dilemma by identifying the source of disagreement as being due to different viewpoints related to the differing backgrounds and the roles of the minute writers. Thus, I could conclude that the differences of interpretation over what had happened was linked to the discourse of these stakeholders that found its expression in these documents.

This approach to the use of documents falls within the participant observation method. Use of documents and indeed interviews to extend the information sources is integral to it (Jorgensen, 1989; Silverman, 1993). Most of the other documents represented the arenas to which I did not have direct access, such as the Department of Health or the meetings of the Regional Health Authority (or, as it became later, the NHS Executive 'outpost'). These bodies have produced a stream of documents, minutes, and guidance notes that were accessible to me by virtue of belonging to the committees and groups outlined above, or by obtaining permission to study a collection of minutes, as was the case with one of the NHS Executive North Thames groups. In addition I have used some of the key documents published by professional bodies mainly in the relevant time period, i.e. between 1995 and 1998.

It can be seen that the sampling strategy here was again a mixture of purposive and convenience.

Thus I have used the following documents or minutes from the same settings as above: Education Boards - 13, GP tutors - 2, Health Authority advisory group - 5, SCOPME - 6, CAIPE - 3. From the Regional Health Authority I accessed five sets of minutes of meetings that I did not attend myself and I have used 16 different documents emanating from DoH or professional bodies.

6.3.5 Validity and reliability

What problems might arise in evaluating my work from the point of view of validity and reliability? First of all, qualitative and quantitative data analysis require different frameworks. One such framework has been proposed by Lincoln and Guba (1985). They suggest four criteria: credibility, transferability, dependability and confirmability. Credibility as a concept is seen to equate to internal validity in the positivist paradigm. How accurate is the account produced? Will it be recognised by people involved in this field? A random selection of six respondents thought that my account represented fairly the situation in which they lived and worked. I would like to suggest that my own immersion in the world of medical education and general practice buttresses the claim for credibility. Transferability corresponds to generalisability. This, of course, is a contested concept in qualitative research, as each area studied is unique, with its own context, rules and norms. Concern with sampling comes into this discussion as well - as my selection of data sources was not random, but purposive, can I argue that they are sufficiently representative? The specifically selected respondents and a considerable section of the documents come from South-east England. Nevertheless, the context I studied is national, and it is possible to see how my conclusions would be applicable nation-wide.

In the interpretive paradigm, dependability as an idea reflects a concern with reliability. In my work dependability was ensured by the use of triangulation of different sources of data and different theoretical frameworks. However, different analysts might use different sources or analytical methods and arrive at different conclusions - this is, after all, the nature of qualitative research. The last criterion is confirmability, that finds its correspondence in objectivity or neutrality. It could be suggested, and I address this issue in Chapter Nine, that personal bias might have skewed my data collection or analysis. The reader, however, has an opportunity to see the raw data in the shape of quotes in the text and to judge my process of analysis. In that sense the work is grounded in the data.

6.4 DATA ANALYSIS

6.4.1 Methods of qualitative data analysis

This group of methods is appropriate to the task of investigating a subject area that is relatively under-researched, where few pointers to the constituent elements and their interrelationships currently exist. In such a situation, an exploratory descriptive work is paramount in establishing the signposts, and in mapping the unknown territory. Further, these methods allow the development of an explanatory framework, from the 'ground up'.

The selection of data analytical methods was determined by the initial interaction with the material. The process of inquiry, asking research questions and data analysis became iterative.

Data analysis initially consisted of a close reading of the interview transcripts and notes of some of the meetings, and the identification of some key elements, without any apparent structure in mind at that point. However, even this preliminary process began to influence the shape of the interviews, the questions I was asking, and also what I was paying attention to at the meetings in my role as a participant observer.

6.4.2 Selecting data analysis methods

Two features of the data I was interacting with began to emerge as important. First, certain patterns or regularities began to appear. Secondly, language used by individuals in the interviews and in the documents appeared to carry important messages. Using Tesch's (1990) classification of qualitative research methods, my interest focussed on two of the four main branches - namely 'the discovery of regularities' and 'the characteristics of language' (p 72). Within the first group, **the grounded theory method** (Strauss & Corbin, 1990) seemed most appropriate to the task.

The reasons for choosing this method were simple. It seemed to me that the whole context of the inquiry, its changing profile within the policy field, and my personal immersion through my work and participation, called for an ethnographic, ground-up approach. The reflexivity required was an essential part of the process - I had to reflect on how much my understanding and interpretations were influenced by my knowledge or my bias as a professional, rather than being the result of a detached researcher. The continuous interaction between the data, the emerging category structure, the theoretical formulations and the data collection method are representative of the reflective researcher.

The second method that proved necessary to employ was **discourse analysis** (Fairclough, 1992). I began to notice when engaging with the expressions or their meanings used by different stakeholders, that the language carried meanings beyond the obvious lexicographic role, and appeared to serve the purpose of moulding the consciousness of the target audiences. Clearly, I thought it was important to try to identify the languages/ discourses mediating the influences of stakeholders in the system of continuing professional education and IPE.

These two methods are described in more detail later on. As suggested earlier, both methods can be accepted into the broad descriptive of ethnography, but the case for discourse analysis is argued in more detail below.

A computer program called Nudist was tried but was found to be inadequate for the task. Instead a straightforward cut-and-paste approach was used, employing the wordprocessor to extract relevant passages from the sources. (See Appendices Three and Four for sources and Appendix Five for an example of a list of coded passages classified under specific codes.)

6.5 GROUNDED THEORY METHOD

Grounded theory

Notwithstanding the description of grounded theory that follows, I need to mention at the outset that I have not used it to develop a theory as described by the authors. Rather, I have used their method primarily for data reduction. Thus, for example, as I will emphasise later, the coding will only proceed through open and axial stages. In the description of grounded theory that follows I draw on my M.Med.Ed thesis (Koppel, 1992).

Originally described by Glaser (1965) as 'the constant comparative method of qualitative analysis', it was later elaborated in a number of publications such as Glaser & Strauss (1967), Glaser (1978), Strauss (1987) and Strauss & Corbin (1990).

Two further features of this method made it appropriate for my work: legitimacy and convenience. It can be considered, as shown later, that its approach to data reduction is consonant with all the major qualitative research data analysis methods. Secondly, in my experience, it is the best developed and described methodology of qualitative data analysis currently available.

Strauss & Corbin (1990)(p 23) describe grounded theory as follows:

A grounded theory is one that is inductively derived from the study of the phenomenon it represents. That is, it is discovered, developed, and provisionally verified through systematic data collection and analysis of data pertaining to that phenomenon. Therefore, data collection, analysis, and theory stand in reciprocal relationship with each other.

The key characteristic is the intimate interrelationship between the elements of the research design and procedure. It is not linear, but recursive work.

Methodology of grounded theory

There are number of elements in the process of analysis (after Strauss, 1987, p 23). The main emphasis in further description is on coding, but some of the elements will be outlined first.

Data collection and theoretical sampling

Theoretical sampling describes the procedure that guides the researcher to collect data on the basis of the emerging conceptual framework. It consequently has an impact on the cycle of data collection and on the process of analysis. In 'full' grounded theory approach data analysis proceeds through three coding stages i.e. open, axial and selective coding¹⁴, and theoretical sampling has different remit at each stage. During open coding one can start sampling data at any point, whilst during axial coding the researcher is trying to crystallise the key concepts and sampling becomes more focussed.

Theoretical sensitivity

This concept, introduced and developed by Barney Glaser (1978), refers to the framework of understanding the researcher brings to his work. A grounded theorist acknowledges the difficulty that stems from the demand that no preconceptions are brought into the study, that the ethnographer approaches his or her subject in a state of child-like naivety. On the contrary a clear awareness of one's sources of information, learning, professional and personal experience helps to control for bias and enhance the progress of the research.

¹⁴ Selective coding will not take place in this work.

Comparisons

Comparison is at the heart of the grounded theory approach. The researcher employs it during the coding stage, comparing one incident with another, or one category with others. Comparison is made not only with the data in the study but also with one's knowledge and experience. Its purpose is to help with the process of progressive abstraction and in uncovering the relevant dimensions of the categories.

Theoretical saturation

Theoretical saturation refers to the point during analysis when it is clear that no new insights, no new relationships are appearing, when the existing relationships between elements of the category appear to hold firmly. It defines the stage when it is possible to stop collecting data for that particular category and concentrate on others. Thus it became apparent during the analysis that the last few interviews contributed little new.

Memos

Analysis requires continuous documentation of the thoughts, tentative conclusions, and ideas for further exploration. Narrative memos are used to keep track of all that intellectual, exploratory and planning activity. They are used to document the various elements of analysis, and later they help with the integration of analytical results.

For the purposes of this study two types of memos were used: theoretical memos dealing with ideas generated during analysis; and methodological memos containing thoughts about the process of analysis, the emerging structures, and ideas for directions to explore.

Coding

Coding in grounded theory is described in great detail, as it is the most crucial stage. It is during coding that the meanings, the concepts, are beginning to be isolated. Its purpose is to search for underlying commonalities in the data to enable the first categories to emerge. Two processes are used during the coding procedure: the constant comparative method (which was the initial name of this analytical method in 1965) and asking questions. It is by constant comparison of units of meaning to each other and later to emerging categories that a network of relationships becomes

established. Asking questions at all stages of the analysis, one proceeds in a Socratic manner, interrogating the data for meaning contained within.

Open coding

Open coding has the function of opening up the enquiry and to begin to interrogate in depth. The most in-depth approach involves analysis of documents line by line, even word by word. This generates most ideas at the early stages of the enquiry, when it is important to get a flavour of the issues involved and the range of possibilities hidden in the meaning of words.

An example is taken from the open coding of a short extract of one interview. Below the line is an extract from my theoretical memo. The underlined words represent early attempt at defining categories and their properties.

‘ ... what we are actually developing at the moment is a core curriculum - or a common pathway - that registered nurses and junior doctors can follow’.

(Nurse educator 1)

Who are we? Who gave them the responsibility and power? What role do the ‘targets’ have at this stage? Are they consulted? Whose agenda is it? How much is the educator and his/ her colleagues aware of any such agendas?

Table 6.4: Grounded Theory - open coding

Asking questions, such as What, Why, Where, Who, How, When, is crucial in teasing out meanings, for it is important not to take for granted the accepted meanings of words. Through comparison, in this case with one's knowledge and experience of developing new courses, one can start discerning the properties of these categories: responsibility can be total or shared, power can be real or imaginary.

Axial coding

Purpose of axial coding

Axial coding denotes the process of developing one category at a time. This category becomes the axis around which the analytical work proceeds. There are three interrelated stages during axial coding, that are described below. These steps are not linear, but recursive .

Identifying categories

The principal categories emerge already during open coding as it becomes clear what are the important issues and processes taking place. Categories are provisional for a considerable period of time as the process of coding moves between stages of coding and category definition.

Process of developing categories

Whilst a category is developed in an abstract way it still needs to be grounded in the data. Theoretical sampling guides selection of incidents for coding and helps with classification and reclassification of categories and their components in the light of the emerging framework. It was found necessary to re-read the interviews and other sources as improved theoretical sensitivity allowed more clues to be picked up. The aim is to arrive to a theoretical saturation of the category when further examples do not contribute further to its development.

Reduction of categories

A process of reduction during axial coding allows the whittling down of numerous categories identified during open coding. This is done by assigning categories to more central, overarching categories. Any new structure thus developed needs to be verified against the data all over again. As the axial coding progressed the recoding produced the final set of six principal codes or themes (the full category tree is in Appendix Six):

NHS/ CONTEXT OF CHANGE;
WHO NEEDS TEAMWORK;
CPD - WHOSE AGENDA?;
WORK-BASED LEARNING;
IPE - NEW KID ON THE BLOCK;
STAKEHOLDERS.

Axial coding - examples

I will use two extracts from the same respondent as above to illustrate how some of the categories begin to interact and coalesce into one of the subcategories of the STAKEHOLDER group.

During the open coding the first quote acquired, among others, codes **technological advances (6413)** (this refers to the first sentence and a need for learners to acquire up-to-date knowledge and skills) and **collaboration - multisite education (64224)** (the learning takes place on the ward but also in postgrad centre). The latter code was attached to the second quote as well, which also

attracted the code, **remit of professional work (6412)** (this is linking two ideas, common curriculum and reduction of junior doctors hours: to cope with the latter imperative, other professionals need to take on some of their functions.). It can be seen that **6412** and **6413** can be subsumed under a higher order category, namely **system view (641)** (in other words, what are the issues in the whole system that are affecting the educational provision?). The code **64224** belongs to a similar order category - **pluralist education (642)** (an education where there are multiple providers, where a degree of competition reigns as they compete for the same 'consumer' group of learners). A dynamic link can be made between these two categories, i.e. changes in the whole system are altering how it needs to operate, in this case by diversifying. Thus a higher order category emerges, that characterises this stakeholder group: **Education as a market (6.4)**.

Training needed that has evolved considerably now with need to know about IV additives, basic life support, advanced life support, peripheral cannulation, arterial gas sampling, biochemistry, bypass surgery, and invasive monitoring. So the actual scope of professional work (in nurses mainly) has expanded significantly over the last few years and we've managed to actually keep up with education in as much as we've managed to underpin the curriculum with a theoretical and practical training element and actually worked with the postgraduate centre as well.

(Nurse educator 1)

And so what we are actually developing at the moment is a core curriculum - or a common pathway - that registered nurses upon registration and junior doctors can follow. Because it doesn't make very much sense to have about five or six different institutions within a different area all doing the same thing when we're fighting for the same resources, when we can actually do it ourselves within one given institution, and obviously this underpins - this is on the back of junior doctors' hours - there's no getting away from that, with the current emphasis being on the reduction of junior doctors' hours.

(Nurse educator 1)

Table 6.5 - Grounded theory - axial coding

Another example will illustrate the developing character of the axial codes. As the first principal category - NHS/ CONTEXT OF CHANGE began to firm up, I did interrogate the data for the stability of the subcategories. Sections 1.2 and 1.4 at the outset appeared to be independent. However, it became clear that there was a logical connection between them and consequently the four elements of 1.4 were subsumed under 1.2. A further process of theoretical sampling identified that category 1.4.4 (Smaller/ autonomous units) could not reach the stage of theoretical saturation and thus was discarded.

1.2 Let markets triumph!

1.4 Pressure for efficiency;

1.4.1 Skill - mix

1.4.2 NVQ

1.4.3 Short contracts

1.4.4 Smaller/ autonomous units

The final shape of this section now looks like this:

1.2 Let markets triumph!

1.2.1 Skill - mix

1.2.2 NVQ

1.2.3 Short contracts

Analytical process in grounded theory

The process described above bears the characteristics identified by Tesch (1990) in her analysis of the principal qualitative research methods. She identified ten such features (p95). However, as this discussion does not add materially new insights, the detailed description is relegated to Appendix Seven.

6.6 DISCOURSE ANALYSIS FRAMEWORK - POSTSTRUCTURALIST PERSPECTIVE ON STAKEHOLDER INTERACTION AND POWER AND POLICY-MAKING

As mentioned in the introduction to the chapter, I have found it necessary to delve into the meanings embedded in the communications emanating from the various stakeholders. It became clear that there was a link between the text (spoken or written), the intentions of the producers of these texts and their behaviour. In other words, one useful way of analysing these connections would be to postulate that these are manifestations of diverse discourses with their inner logic and structure, whereby identification of their components, penetration and influence on other discourses can aid in understanding how the field of CPD and IPE is constituted.

I propose here to outline briefly the history of discourse analysis, and my justification for choosing one particular approach to it. This is followed by a description of the methodology and method

used, with appropriate illustrations detailing the steps taken to arrive at the shape of the three discourses. The discourses themselves will be described in detail in Chapter Eight.

The reader will notice that the history as presented here is rather brief, as the intention is to introduce the development of the key ideas and some of their critiques, rather than to analyse these in detail. This brevity admittedly results in some density, which however improves on moving on to the discourse analysis itself. The presentation is in two parts - the first dealing with a broad group of text analysis methods, the second outlining the variety of discourse analytical techniques.

6.6.1 History of discourse analysis - text as a focus of analysis

It is worthwhile stating that the field of discourse analysis (DA) is complex. This is not surprising, as it crosses numerous academic disciplines, addresses itself to different parts of the 'discourse' and its meaning and action. Van Dijk (1997 a) traced the history of DA and suggested that it represents a confluence of two broad traditions - humanities (and more specifically linguistics), and social sciences (and more specifically sociology). As Silverman (1985) pointed out, approaches to text analysis (besides content analysis and ethnomethodology) in the Anglo-Saxon world were marginal in sociology - i.e. they were delegated to linguistics and humanities. The reason might be disciplinary allocation - 'words' belong into humanities and 'structure' into social sciences, whilst French culture (p149) 'creates unities around 'methods' rather than 'disciplines'..

The roots of DA reside in the approaches to text analysis that problematise the apparent, communicated 'truth'. Manning and Cullum-Swan (1994) divide these into three broad categories - content analysis (which will not be addressed any further here) and narrative analysis; semiotics; and structuralism.

Narrative analysis

The varieties of approaches included under this banner represent more of the interpretationist end of text analysis (as contrasted with content analysis), but there is a spread from structure- to a wholly subject-centered interpretation. Nevertheless, the focus is mainly on the structure of the text. Only some of these approaches to the analysis of narrative will be mentioned here.

Analysis of formal narratives such as a medical interview or consultation provides an important building block in understanding the different perspectives brought into human interaction. Focus and the understanding that results vary according to technique used. Thus we can see an analysis of the stages of consultation with relevant emphasis on the processes contained within each stage

(Havelock, Pendleton et. al., 1984) that approaches it from the stance of social psychology, or an earlier attempt at analysing the consultation from a point of view of doctors styles (Byrne & Long, 1975). Yet another, more complex approach looks at the physician-patient interaction from the vantage of medical anthropology by asking questions such as : why me, why now, what does it mean? (Helman, 1990). Within this group falls Silverman's (1993) approach to analysis of formal, institutional talk manifest in the medical interview. Unsurprisingly, one of the findings of this research is the inequality of power in that encounter.

The feminist approach to analysis of narrative introduces a different perspective (West, Lazar, & Kramarae, 1997). Here the focus is on the story that allows for multiple voices, where the constructed narrative (between subject and narrator) may not relate to a 'real', commonly perceived or agreed social reality, but has a reality of its own.. It also points to gender differences in narrative and styles they use. This collection of techniques is intended to help to understand life experiences from women's point of view.

These approaches begin to point a way for an analysis of power relationships and the processes involved in shaping the thinking and behaviour of social groups.

Semiotics

As van Dijk (1997 a) noted,, the text has been a subject of analysis by literary critics, historians, researchers from within mass communication research community as well as by linguists.

However, de Saussure (1974) brought a fresh impetus into the analysis of language and can be considered a father of structuralism (more on this later). He also extended the remit of analysis beyond the language to other forms of social communications, such as social etiquette or even road signs. Hawkes (1977) (cited in Silverman (1985) p 56) suggested that de Saussure's reform consisted of two aspects. First, the link between the words or signifiers and their meanings is not fixed, but relative or arbitrary. Thus a signifier (a word or hand signal) links to the signified (or the associated concept) in a socially agreed manner, but is not in any way determined by such a concept. For example, word 'chair', in itself it does not contain the idea of that physical object, that would be instantly identifiable to any stranger to this word. The sign itself is a combination of the signifier and signified, e.g. a sign of a stick 'female' in a public place will signify both a presence and direction to a toilet facility. A second key idea of de Saussure's is to reject the notion that the historical links between the signifier and signified are the only determinants of the meaning. Instead, he suggests, the links needs to be analysed in their current context. This is visible in shifts of meanings associated with words such as gay or holiday (holy day).

Semiology (the study of signs) is interested in uncovering the 'language' (or 'langue') (the structured conglomerate of signs) through analysis of 'speech' (or 'parole').

Silverman (1985) p 149 summarised these propositions and their importance:

Words are not a preliminary to investigation of reality, they are reality in their own right. So the move outside the system (into history or social structure) can be illusory and reductivist.

Fairclough (1992) identified a limitation of de Saussure's contribution in his key proposition that production of 'parole' is individualistic enterprise and thus not amenable to systematic study. Further developments in semiotics move away from this position (Manning & Cullum-Swan, 1994). Signs are seen as not determined from outside, and thus they do not constitute a unified whole. The relations (i.e. the embedded meaning) between them and reality is re-articulated in use (the discourse). The culture of the society or a particular social subgroup builds up from a shared meaning of signs in the form of rules, implied knowledge, behaviour and thought practices. There appears to be some reciprocity in that culture imposes some constraints on the range of meanings - so arbitrariness (the 'anarchy' in Silverman (1985)) is restricted. Fairclough (1992) within a Marxist paradigm identified this codification of meanings as ideologies which embody assumptions about the power relationship between discourses or the groups/ classes they represent.

It is also possible to understand within this framework of thinking how techniques of influencing populations, their attitudes and behaviours, work. It would need to start from the current perceived reality, understanding of the key cultural and historical referents, and progress to re-articulating these elements, through use of propaganda. This might be seen at its clearest at times of conflict or war with a group or nation that has hitherto been an ally. With propaganda a re-interpretation of the past and present, of the values, behaviours and intentions of the 'enemy' is offered, thus the relationship between the 'parole' and the 'langue' changes.

In the view of Manning and Cullum-Swan (1994) (p 466):

Social semioticians see social life, group structure, belief, practices, and the content of social relations as functionally analogous to the units that structure language.

However, they also suggest that the weakness of structural semiotics is that it is unable to account for history, for changes in meanings and the interaction between self and group. Fairclough (1989)

from the stance of critical theory, in addition, labelled it 'asocial' as it ignores links between language, power and ideology.

Structuralism

Structuralism (with post-structuralism) represents the third strand in the development of discourse analysis.

Building on de Saussure's analysis, structuralism applies linguistic analysis to social 'text' (actions, expressions) to uncover underlying structures (conglomeration of meanings - signified) determining the signs (signifiers). Methodologically it is based on the comparative method, seeking this correspondence and building up of the explanatory structure. The researcher seeks to identify the rules or conventions determining the accessible expressions. The reality, as perceived and normally accepted, is constructed and re-constructed through use of signs, be this language or reading of social norms.

Silverman (1985) is critical of structuralism for its 'anti-humanistic' stance, its not giving a priori value to human intentions, nor recognising a person as a centre of investigation. Structuralism does not offer a philosophical view of human action and intentions - rather it is involved with a need to understand the 'articulation' of meanings within a particular system of the concepts relating to definition of human self and societal interaction.

Poststructuralism

Poststructuralism has been mentioned in Chapter Five in my outline of Foucault's conceptualisation of power and discourses.

As a loose conglomeration of philosophical approaches it has developed under the influence of Foucault (see Chapter Five) and others such as Lacan (1977), Bourdieu (1977) and Barthes (1980). It builds on, but moves further from, the structuralist project by accepting relativism and unknowability of the underlying structures, and therefore it is the text that becomes a primary focus for analysis. Poststructuralists suggest that we need to see the text reflecting the multiple voices of the dominant (the author/ interpreter) and the marginalised (the passive objects, the non-white, women, and minorities). I will look at the contribution of Barthes in little more detail to illustrate the key philosophical and analytical concepts.

Barthes belongs to group of poststructuralists and his approach to the analysis of texts is intentionally anti-positivist. He declines to use a rigorous methodology and advocates instead 'a

mobile structuration of text' (Barthes, 1980) (p 113). It is the reader who is at the centre of analysis that relates to other texts and meanings both within a reader and a wider context. Barthes talks of 'codes' as means of creating a temporary structure, codes that resonate with the embedded meanings - 'these voices (whose origin is 'lost' in the vast perspective of already written)' (Barthes, 1975) (pp 20-21.). He distinguishes this approach to text analysis from hermeneutic and Marxist analyses with their search for truth and meaning. His intention, instead, is to listen to multiplicity of voices, to see interacting perspectives.

Codes, in Barthes analysis, appear to stand for description or translation of relationships observed or inter-textually identified such as symbolic, narrative, rhetoric, code of communication and metalanguage, chronological, or socio-historical. Codes in Barthes' hands are cultural constructs, ways of referencing the elements of narrative. Action sequences are identified as structures around which narrative unfolds, but careful analysis shows a number of these proceeding simultaneously. He suggests that it is necessary to identify narrative as having a life of its own, that it does not transparently represent reality. It is therefore essential to accept 'structural duplicity of all writing'.

6.6.2 Discourse analysis and its varieties

Having outlined, all too briefly, the contributing strands to inquiry into text (and to re-emphasise that it stands for spoken, written or other forms of communications), I will now look at some of the approaches to discourse analysis itself.

As van Dijk (1997 a) noted, this field can be divided into two principal groups, each treating the discourse from a different angle. The first group focuses on discourse from a linguistic point of view, by paying attention to verbal structures, their order and form, the embedded or assigned meanings, the style and rhetoric employed.

The second group looks at discourse in a more dynamic way, from a social science point of view, by analysing its function in societal actions and interactions (van Dijk, 1997b). Thus these studies are contextualised within a specific class of settings, such as institutions or organisations, within different expressions of social life, such as culture or politics, or through addressing specific tensions, for example issues of gender or ethnicity. Inevitably, the issue of power looms large here, be this present in the explicit form, e.g. in political life, or more embedded, in human interaction e.g. in gender relations.

From the above it is clear that the definition of discourse and its remit will vary according to the disciplinary orientation of the analyst (some work as social psychologists, whilst others would identify themselves as 'students' of culture). The definition of discourse that I am using in my work relates much more closely to Foucault's definition, whereby the discourse refers not only to the language's representational aspect, but more importantly to its function as a social action, in that it is actively involved in shaping the social interactions and structures. Or as Fairclough and Wodak (1997) put it (p 258):

Describing discourse as social practice implies a dialectical relationship between a particular discursive event and the situation(s), institution(s) and social structure(s) which frame it.

As I am relying on Fairclough (1992) as a principal source for my approach to discourse analysis, I will in this section follow very much in his footsteps in outlining the approaches to discourse analysis against which his schema then can be understood. Consequently, these approaches fit more comfortably in the second, socially-oriented group.

Discourse and society

Fairclough (1992) divides this group of approaches to DA into two opposing categories - those that are in his view 'non-critical', and those that like himself build on a critical theory.

Non-critical discourse analysis

Sinclair and Coulthard (1992) have taken a structuralist approach to analysis by dividing the discourse into components that move from a higher to lower level of complexity. An example from an analysis of school interactions would be: 'lesson', 'transaction', 'exchange', 'move' (such as an answering move that occurs in a response to an opening move in exchange) or 'act' (a speech act is an utterance with a specific role, such as to inform or mark a verbal intervention). The strength of this approach is in correlating situational factors with the linguistic elements of the talk. Its limitation is a lack of awareness of social context, thus ignoring differences in power and frequently in social class that inevitably would shape such classroom exchanges. Furthermore, the diversity in classroom practices and experience is not catered for.

Conversation analysis (Pomerantz & Fehr, 1997) has considerable links with narrative analysis (see above) especially at the formal end, dealing with institutional discourses. It has been developed by ethnomethodologists; so while it is at the interpretive end of analysis, it has equal concern with structure, context and content. However, the researchers are focussing more on structural elements

in conversation production ('enriched positivism' (Holstein & Gubrium, 1994, p266). Nevertheless, they allow for a move between these elements - talk is located in a local context, and in turn it affects the other participants and their responses and actions. The weakness of this analytical approach is similar to the above position in that it neglects the factor of power and relies too much on structural elements determining interpretation.

Potter and Whetherell (1987) critiqued traditional approaches in social psychology which ignore situational, contextual dimension of language and consequently the variability in 'participants' accounts' (p 35). In other words individuals' thinking, utterances and behaviour are affected by the context, which can explain the constructive contribution of discourse. They take an example of research into attitudes which they argue can be misleading as these are not examined in different contexts (and these might include indeed the researcher's presentation or formulation of the research question). Potter and Whetherell extended their argument into the domain of analysis of speech - they contend that content has frequently been neglected in favour of form. Fairclough (1992) criticised their limited development of DA. Thus boundaries between form and content may not be as rigid and in addition their definition of content leaves out the interpersonal dimension of discourse.

Critical approaches to discourse analysis

Here we begin to move much closer to Fairclough's domain. The group of analysts mentioned here in the main draw on critical theory of the Frankfurt school - (such as Marcuse, Habermas (1984), Adorno). This development in Marxist thought challenges the traditional approach to analysis of society and the role of individuals by giving equal attention to the inner world, away from the exclusive deterministic stance that postulates the primacy of societal structures (Blackledge & Hunt, 1985) (p121):

Its aim is with the development in men of that critical consciousness or awareness which enabled them actively to seek their emancipation from repression.

Politics are seen as the main determining forces in society: and to achieve a desired change we need to study individuals with their ideology, their construction of their place in society and their awareness of the degree of power they might possess.

Critical language analysis (Fairclough, 1989 & 1992) builds on linguistic analysis and critical¹⁵ theory (neo-Marxist), focussing on struggle for power as it is reflected in the language, and where

¹⁵ 'critical' refers to intent to uncover hidden meanings and hidden effects

language is seen as a primary control mechanism. Ideology (of power) permeates and shapes the assumptions and thus manufactures consent (in the absence of conscious struggle). Interpersonal meaning i.e. social relationships are reflected in way they are classified. Fairclough (1992) identified a weakness of critical language analysis in its concentration on text analysis, where close correspondence between grammar and social underpinning is assumed while ignoring the variability of social context of text '...distribution, consumption and interpretation...'.(p28). Its epistemological stance is questionable too as it represents a more classical Marxist view of social reproduction, while ignoring the more dynamic option of social transformation based on a notion of an interactive process between social structures and individuals.

Critical discourse analysis (CDA) (Kress, 1993; Fairclough & Wodak, 1997) proposes a theory of 'motivated relation' between signifiers and signified. It thus represents critical linguistics that challenges underlying assumptions of many linguistic analyses that ignore the social dimension of discourse production. The signs, according to CDA, reflect characteristics of their producer and his/ hers physical, social, conceptual, cognitive and cultural features that contribute to the motivation to produce a sign. Boundaries of signs may appear arbitrary, a matter of individual choice, but the proposition here is that social-political reference will determine the boundary. Power is a key determinant - greater control results in tighter boundaries. Dowling (1996) criticised CDA as using linguistic analysis as a primary tool and for its suggestion that social structures are moulded by the discourses without any degree of reciprocity.

It now can be seen in which direction the Fairclough (1992) schema is moving. Some of its salient features flow from its predecessors and the critique of these approaches (p 35):

- analysis needs to centre on specific linguistic texts that represent diversity of practices,
- the processes of text production need to be studied and the analyst needs to acknowledge his own biases,
- social changes as reflected in discourse need to be identified,
- attention is on the discourse as a socially constructive force and the impact of discourse on the power struggle and conversely of power on discourses,
- the role of discourse in transforming and maintaining ideologies is central,
- there is a need to acknowledge diversity of meaning and forms of language of both interpersonal and ideational kind.

6.6.3 Discourse analysis - methodology

I have based this framework on the one described by Fairclough (1992). He postulated that a discursive event needs to be seen, and discourse analysis needs to proceed, in three dimensions - as a piece of text, as a discursive practice and as social practice. The process of data analysis has been guided by paying close attention to the implications of the discourse manifestation in the data. Interest focuses on how the subjects of the discourse are constituted, how the social structures are re-shaped, and how in turn these structures and intentions of subjects alter the power discourse.

Theoretical note

The work by Fairclough (1992) provided a convenient starting point. He synthesised two of the major strands that I have found useful for my discussion - the concept of power as articulated by Foucault and the notion of hegemony propounded by Gramsci. There are some differences between Fairclough's conceptual foundation of the analysis of discourses and the way I have chosen to construct it. This, however, does not invalidate using his basic framework.

Firstly, I have used a wider reading of Foucault on power (as detailed in the Theory Chapter) than just Fairclough, and in addition I make use of authors that have looked at education from Foucault's viewpoint such as Ball (1990 c). Secondly, I make much less play of the concept of hegemony in this instance than Fairclough. Nevertheless, some reference to hegemony was useful in the discussion in Chapter Eight, especially when trying to distinguish between the roles and behaviours of different stakeholder groups in relation to power and discourses.

Lastly, I made little use of one other angle of Fairclough's approach. His analysis at the level of social practices specifically looks at the ideology underpinning social change. While this is, of course, important, and I have made a number of references to it when analysing the context of the NHS changes (see Chapter Two) that provide a background to an understanding of the place of CPD and IPE, much less explicit use of it is made in this section, or rather the ideology is conceptualised differently. In that sense I am following Foucault more closely, as he was opposed to accepting the notion of ideology as a perspective for understanding the workings of power in society. He saw three reasons for not analysing ideology (Foucault, 1980) (p118):

The first is that, like it or not, it always stands in virtual opposition to something else which is supposed to count as truth. ...The second drawback is that the concept of ideology refers, I think necessarily, to something of the order of a

subject. Thirdly, ideology stands in a secondary position relative to something which functions as its infrastructure, as its material, economic determinant etc.

And he argued (p77):

The longer I continue, the more it seems to me that the formation of discourses and the genealogy of knowledge need to be analysed, not in terms of consciousness, modes of perception and forms of ideology, but in terms of tactics and strategies of power.

All of the strands of this argument are congruent with his conceptualisation of truth, knowledge and power. Foucault posited a close interrelationship between knowledge and power, as he did not see them as separate entities. Likewise he was suspicious of any suggestion that an absolute truth can exist, truth that is not contingent on its context. The clash of ideologies then represents a clash between claims to a legitimacy of truth, of offering a 'true' picture of how the social world functions. Power is linked to such a claim.

In short, the concept of ideology is not explored in this section as an independent entity, but is considered more when I synthesise the insights gained during the various stages of the analysis.

Instead, I would like to propose viewing the policy-making and ideology of the stakeholders (and I am suggesting that there is a close link between them) more in the light of the Foucauldian notion of power techniques. As Clegg suggested in his commentary on Foucault's ideas about power (Clegg, 1989) (p177):

In the terms of the realist epistemology, the relative intransitive causal powers of agents and the appropriate standing conditions for their expression must themselves be regarded as an effect of power.

In other words, ideology, for example, is not a disembodied theorisation about the world and how it ought to function, but is an expression of a power discourse. Therefore, I looked at the policy-making in relation to CPD and IPE in this light - what does the policy-making process say about the discourses permeating society at this time?

Discourse analysis - from theory to practice

How can the Foucauldian framework be translated into a tool for an analysis of discourses and associated social practices? Fairclough (1992) suggested discourse needs to be seen as a mode of representation (a more classical view of language use) and a mode of action or dialectical interplay

between it and the social structure. This perspective is at the heart of his proposition - discourse shapes the social world, but is in turn constrained by it. The attention is on the two principal constituting effects of discourse - on subjects and the social reality. The analysis used Foucault's conceptual perspective elaborated in the Theory Chapter, where the technologies of power were outlined - namely normalisation, examination and classification, confession, surveillance and gaze and the manifestation of the impact of power-knowledge.

Three dimensions of discourse

I need to come back to three dimensions of discourse as specified by Fairclough: text, discursive practice and social practice. The analytical techniques relating to each of these respectively are: linguistics; the interpretationist approach to an analysis of discourse (the microsociological perspective); and macrosociological (incorporating both structuralist and functionalist perspectives). I need to point out at the outset that the analysis, as presented further on in the discussion, blends all of these techniques to create a comprehensive whole.

Coding of text

How did I approach the coding of the text? The process combined DA method and grounded theory technique. Discourse analysis resulted in identifying the principal components of the three discourses and their impact on other stakeholders, and also their relevance within CPD and IPE. The grounded theory approach described earlier in the chapter aided in constructing the category structure through its process of iterative questioning of the texts, until a theoretical saturation was reached. This was essential as it was imperative to establish the robustness of the findings. See the category structure in Appendix Six.

Text

Analysis of forms and meanings needs to proceed simultaneously, the 'signified' needs to be combined with 'signifier' (see discussion on de Saussure earlier). Fairclough (1992) suggests, in opposition to the value neutral approach of de Saussure, that the linkage is in fact socially determined and reflects the underlying political and ideological stance. The task of interpretation has been to move from a range of potential meanings of a text to the ones that are socially embedded, specific and reflective of circulating power relations. Thus the link between power and knowledge is pointed out.

Analytical categories considered are vocabulary, grammar, cohesion, text structure, interactional control and modality.

I will look closely at two examples, each representing a specific discourse and will point out the textual categories contributing to the analysis. The first example will concentrate on analysis of words, their meanings and modality (a degree of affinity with a proposition, in other words a strength of association). Some of the questions within these categories that need to be posed, as suggested by Fairclough (1992), could be respectively (p 237): 'Does the text contain new lexical items, and if so what theoretical, cultural or ideological significance do they have?'; 'What is the potential of the word(s) as locus for expression of hegemony and ideological struggle?' and 'Are modalities predominantly subjective or objective (explicit or implicit)?'

This example is taken from a NHS Executive circular detailing the process of how educational consortia ought to be established and to function, and it represents an item from within the management discourse.

Consortia should provide a forum to link service objectives with workforce planning to enable the development of a flexible and competent healthcare workforce able to adapt to the changing nature of service delivery.
(NHS Executive, 1997)

I will propose here that 'workforce planning' is a new lexical item, that is congruent with the introduction of a business ethos into public services, and while it may have occasionally surfaced before 1990s it is at the centre of management thinking currently. It implies, together with the expression 'healthcare workforce', a degree of objectification of the people working within NHS. Through this device, from being individuals with their particular needs and abilities, they are reduced to items on the balance sheet, becoming disembodied and subject to manipulation. The implication for the thinking and culture of the management class is obvious - professionals are just a necessary cog in the machinery, no more, no less. The shift of power is strongly embedded in this message, so much more when the adjective 'flexible' is taken into account: here the need is for professionals to adjust their patterns of working according to the needs of the organisation, rather than individual patients. The modality expression 'should' has a high affinity and is explicit. This implies a direct line of command from high, where this system design was conceived, a command that cannot be ignored.

Next I will focus on some of the other aspects of the text analysis, namely on interactional control (how issues of power are represented in the organisation of discourse) and cohesion (how clauses

and sentences are linked). The relevant questions might be (Fairclough (1992), p 234-5): 'How are topics introduced, developed, and established, and is topic control symmetrical or asymmetrical?' 'How are agendas set and by whom?' and 'What functional relations are there between the clauses and sentences of the text? '

The second example comes from an interview with a GP educator and falls into the category of 'the building blocks' of the discourse of professions.

If the practice of medicine is a serious thing and the patients who come to us have serious concerns about their health and may have quite serious illnesses, then we have a duty seriously to undertake a preparation of ourselves to deliver a service for them. I think you can, it's possible to get people to share that vision.
(GP educator 1)

Two discourses coalesce here - the management discourse where this individual can be seen to want to influence the behaviour of his fellow GPs, and the professional discourse on which I will concentrate. This speaker argues for an altruistic view of medical profession and against the trend towards devaluing professional ethos. In this case the conditional 'if' can be taken as a rhetorical device, problematising the accepted ethical commitment of the medical profession, in order to highlight the absurdity of removing the responsibility for organisation of proper care and for the maintenance of competence from the professionals. There is a strong implication here that the control of the debate is asymmetrical, that the agenda is dictated from above. The cohesiveness of the text appears transparent, the word 'serious' being repeated three times underlines the key message. But it also links the three components of the extract - patients with their illnesses, the medics with their commitment to care, and a need to continue learning.

Discursive practice

Discursive practices are: production, distribution and consumption of discourse (Fairclough, 1992). Analysis at this level is concerned with identifying which elements of discourse (in this instance mainly text) and which 'members' resources' (motives, desires, comprehension) are used, and how meanings are constituted.

I will address myself to text production first. Questions that can arise in this context are concerned with the components of the discourse, what types or genres are manifest within it, and the distribution of discourses in the text (Fairclough, 1992) (p 232). The last point is fairly straightforward: all of the discourses here permeate all the data sources - documents, interviews and social interactions (as noted in my field notes). The documents themselves will show different

genres, according to their origin and role. Thus a circular from NHS Executive (as seen above) will set out directives for action to its recipients, primarily the managers in trusts, and it will consequently be formal, exhortatory, but with a considerable degree of instructional force. Minutes of the meetings, on the surface, are designed to record and inform, yet their formal and apparently neutral style can hide an embedded message consonant with the prevailing discourse.

The following extract from minutes of education board will illustrate this contention.

Benefits to GPs include: identification of key performance indicators and crucial factors regarding service provision, continual increase in Quality of service provision with proof, Service/Professional Development/Innovation of effectiveness and Increased Professional Profile.
(Education Board minutes)

The text is from a request for funding from a Medical Audit Advisory Group (MAAG) to develop a benchmarking approach to quality assurance in general practice. The overt recipient of this communication are the funders, and thus the text is consonant with the management discourse within which this MAAG group operates. The embedded message is not only that quality of care needs to be improved, but that measuring the performance of GPs is to their advantage. The appeal of this style of communication is to both management and the professions, but it positions the latter as being in a win-win situation. To argue against this proposition would seem churlish.

Consumption is linked closely to distribution - frequently distribution anticipates its intended target audience. In the above example at least two different audiences (managers and professionals) are addressed. Production and interpretation do not occur in isolation - these processes reflect past and present individual and organisational practices and social structures. Further, it is necessary to identify how the discourse might transform itself during its distribution and what it activates in the process. The example below is from a meeting when initial plans for allocation of new money for GP education are being discussed.

Here (at LIZEI meeting) we have GP educationalists and managers talking about the great unwashed masses - what they need to learn and how, and what we'll prepare for them - them and us (paternalistic approach). Pragmatism versus idealism - grabbing an opportunity. Agreeing on definition - what is a problem/ can we label it, whose problem is it.
(Field notes - Education Board)

While the original intent is to help London GPs to cope better with their work through increasing educational opportunities, this facilitative stance hides a negative perception of (at least a subsection of) this cohort, who are not maintaining their professional obligation to keep up-to-date.

This discourse activates dormant attitudes within the intermediate group of managers and educationalists who now have their power-knowledge augmented with financial clout. The transformation is complete - the helping hand acquires an accusatory finger.

The production and interpretation of a text is the result of bottom-up and top-down forces, where meanings are constituted in a power dialogue. The discourse of life-long learning could be seen in this light. The interplay of a fast-changing social and economic environment and the expressed need of the state to maintain progress is a meeting place where individuals and institutions are forced to reconsider their approaches to their self-management as productive units. Life-long learning emerges in that cauldron of pressures and interests as a technology for equipping individuals to be flexible and capable of change. This makes them more open to the effect of the power technologies, and they will more willingly subject themselves to surveillance and examination in order to prove their capabilities in the new order. This is evident from my observations of the tenor of the discourse running through various contributions at a postgraduate conference.

Tension exists between the needs of professionals to be up-to-date (i.e. CME), whereas managers are interested in a wider form of development, moving beyond a pure clinical set of knowledge and skills - this falls under the label of CPD. And a pressure is on professionals to accede to this pressure.
(Field notes - CPD conference 1)

This aspect of the management discourse has been absorbed into professional awareness, even if there is an implied resistance present - the pressure is on, but not everybody has acceded to it. One could ask where is the unconscious aspect of the discourse. The answer is deceptively simple. Two processes seem to run side by side. On the one hand there is a ready acknowledgment that the context of professional work has changed, but on the other, there is a letting go of a hitherto treasured professional independence through acceptance that a more organised and transparent format of professional updating is necessary.

Intertextuality

The concept of intertextuality needs some elaboration. It links the text and the discursive practice. I have not used it in the precise way Fairclough has specified it, as he links it closely with the ideology. My interpretation of this term is closer to his concept of interdiscursivity or constitutive intertextuality. In my analysis intertextuality refers to the manifestation of a different discourse in a piece of text, but also in a practice (in Fairclough parlance it is labelled 'manifest intertextuality').

Thus, for example, it is possible to identify in a policy document, say from a professional organisation, a mixing of a discourse of excellence, that suggests that standards of professionals have to be maintained through commitment to CPD, with a discourse of management with its rhetoric of accountability for the use of resources. A quote from an interview with an UKCC officer shows how the two discourses are mixed and appear to be sitting side-by-side.

We (UKCC) found, that largely because it's such a disparate profession in terms of educational standards, level of preparation and so on, even though we would have liked to have left it to the individual, and indeed one of the clauses in our Code of Conduct is about maintaining knowledge and competence, but the blunt fact is that unless you put some sort of sanction in there, people won't do it. Their employers won't support them to do it either.
(Professional body officer 1)

The Code of Professional Conduct (UKCC, 1992) uses words such as 'must ... maintain and improve your professional knowledge and competence', and thus already links the professional discourse, with its emphasis on self-awareness and internal motivation, with a management discourse permeating the role of this regulatory body. Traditional professional accountability in the brave new world of contracts and penalties is found wanting, the regulatory body needs to be seen to play its role in policing the profession in a much tighter way. The threat of sanctions, in form of removal from the register thus removing the means of earning a livelihood, is then the overt manifestation of the new management discourse, that drowns the voice of professional autonomy.

Social practice

Here I depart from Fairclough's schemata (Fairclough, 1992) substantially, since for him ideology and hegemony constitute the principal building blocks for an analysis of the impact of discourse on the social world. As mentioned above, I am not considering ideology to be the determining factor in the discourse analysis for this thesis. Hegemony, on other hand, as I have defined it has assumed a connotation different from that of Fairclough (and Gramsci) - that is, which structure or group has acquired a power and is able to use it to influence other groups. They see it in Marxist terms as a class struggle for power in society as a whole, whilst I am looking at the interplay of interest groups in the welfare state. Hegemony will then feature in the process of analysis, as I am focussing on the social practice of discourse in terms of an interaction between the discursive practices and the social and institutional practices. It is at this level of analysis that the social and historical perspectives are brought into play, where an understanding of the social structures and the expressions of power in a society shapes the discourse practices. How have the institutions developed their processes and procedures? How stable are these? Is it possible to see them as

expressions of previously prevalent discourses? In the last example it was possible to see the interplay of some of these elements, whereby the regulatory body responded to circulating management discourse by altering its working practices. Another example comes from my reflections on the proceedings of an education board.

Power through: providing info, and making decisions - board is being used to rubber stamp these or make limited decisions on agenda presented primarily by FHSA; through control of money, through having more time to interact with GPs, through having developed a Professional Development Strategy - that incorporates LIZ 'flexibilities' possibilities. So what is the role and power of the board? - is it just to satisfy wider public of GPs that a democracy really exists - note a call for transparency - or to inform all GPs of criteria to be used for selecting/ approving requests.

(Field notes - Education Board)

I have noted how the board's actions and procedures are moulded by the prevailing power discourse, the discourse of management. The power-knowledge, contingent on its being in an intermediate position between management 'proper' and the health care professionals, gives it opportunity to crystallise it in the shape of the development strategy. This provides a template against which all the educational, developmental activities would be judged, and thus the board accepts a surveillance role. Yet at the same time, since it consists of professional themselves, albeit in an education management capacity, it subscribes to the notion of professional autonomy and accountability to its constituents. This egalitarian concept needs to be squared with its management role. It can be seen that the situation is not stable; changing demands force a revaluation of its activities and norms of conduct. This is hegemony in action - whilst the power is with the management class, it needs to create and maintain alliances with other groups.

In this way, by looking at social practices, the key impact, the constituting effect of discourse, can be analysed. How does discourse constitute the individual subjects? How does discourse constitute the social reality, social institutions and practices? The development of ideology and the policy-making process can begin to be understood in this context as an overt manifestation of a societal power discourse in institutional life and state governance.

6.7 SUMMARY

In this chapter I have outlined the data collection methods used, namely interviews, participant observation and documentary analysis. Further I have described the two principal analytical methods and their theoretical underpinning - grounded theory method and discourse analysis. I have put forward my reasons for selecting these methods and what modifications were found

useful, especially in the discourse analysis. Having illustrated the process of my approach to data analysis in some detail with both of these tools, the next two chapters will show how these approaches and their results contribute to the development of my thesis. Whilst grounded theory method informs both of the following chapters, discourse analysis is used more extensively in the discussion in Chapter Eight.

7 CHAPTER SEVEN - DISCUSSION: UNDERSTANDING THE CONTEXT FOR CPD AND IPE

7.1 INTRODUCTION

The study had the following four aims:

1. To develop a **contextual framework** of the key issues relevant to an understanding of interprofessional education (IPE) and its place in continuing professional education/development (CPE/ CPD) in health and social care professions.

The study required building a picture of the changing health care and professional education scene, presented respectively in Chapters Two and Four. Additional background to the thesis pertaining to teamwork was offered in a concise form in Chapter Three, but the bulk not relating directly to IPE is in Appendix One. This represents the scholarship element of this thesis and my intention is to argue that these chapters are able to stand independently from the research element.

2. To develop a **theoretical framework** for an analysis of empirical data exploring IPE and CPD and their relevant contexts.

This framework was outlined in Chapter Five and provides a backbone for the discussion within this and the next chapter.

3. To **critically evaluate** the emerging picture of IPE and CPD and their relevant contexts on the basis of this theoretical framework.

This evaluation is the subject of this chapter.

4. To **investigate how IPE and CPD feature** in the thinking and practice of key players who are identified as policy makers, educators, employers, and the professionals themselves.

The next chapter is devoted to this task.

7.1.1 Advanced postscript

A number of changes have occurred within the organisation of the welfare state since the end of data collection in early 1997. The most important one has been, of course, the victory of the Labour Party in the parliamentary election in May 1997. This has had a profound effect on the direction and organisation of welfare services.

These issues are not addressed in the discussion as part of an analysis of the results, as the changes in policies and legislation occurred after data collection. Nevertheless, reference is made to them if appropriate - for instance when the new Labour administration's intentions follow the direction of the previous Government.

Key changes involve the dismantling of the internal market, legislating for co-operation between the health and social care sectors, and the establishment of Primary Care Groups (Department of Health, 1997a). The new legislation has abolished the internal market to avoid the inefficiencies of high transaction costs of associated administration, while keeping the separation between the planning and provision of secondary care. The most prominent aspects of this change is the termination of fundholding arrangements, that allowed GP fundholders to purchase care directly from hospitals, thus gaining an advantage for their patients in comparison with the patients of non-fundholding practices.

Partnership at local level between different parts of the health service and the local authority is seen as essential for efficient and patient-centred service. Thus, a locally agreed Health Improvement Programme allows ownership of the desired change in service provision. All the stakeholders are involved in formulating these and are expected to take responsibility for its implementation.

Primary Care Groups have been established in localities to take over the responsibility for health care for a defined population of approximately 100,000. It is envisaged that as these organisations progress to so-called Primary Care Trusts they will be able to take on board commissioning for social care in close partnership with the local authority, who will be an integral part of these new arrangements. Devolution of responsibility for planning and delivering care to Primary Care Groups needs to be underpinned by effective co-operation between constituent stakeholders.

7.1.2 The process of analysis

The discussion in this chapter integrates empirical findings and the relevant background literature pertaining to IPE and its context, by using the theoretical framework outlined in Chapter Five.

For clarity, I need to re-emphasise that I have incorporated the data, in form of quotes into this and next discussion chapters. Thus I have considered it unnecessary to have a separate results chapter. I must once again stress that this work is not a survey. I am not attempting to compare and contrast the views and opinions of different contributors, rather I am looking for emergent themes that illuminate the changing world of the welfare state. Where differences do occur these are pointed out, as for example is the case with varying stakeholder views on CPD..

The main themes identified during the analysis, namely the context of change, teamwork, continuing professional education, work-based learning and interprofessional education, are addressed in turn.

7.2 NHS - THE CONTEXT OF CHANGE

In what way is it possible to conceptualise and understand the change processes in the welfare state? Can different theoretical perspectives offer an opportunity to gain a more complete picture? There are some key themes that will appear throughout the rest of the thesis - most specifically the imposition of change with the attendant rise of managerialism, set against the backdrop of market orientation within the welfare state. I start by briefly describing these themes.

7.2.1 Imposition of changes

As has been alluded to in the introduction to this thesis, a centrally organised health service is one of the hallmarks of the modern state. It is one of the means whereby the government is able to express its ideological stance towards the format of the welfare state and attempts to exercise its influence on the population. However, direct bureaucratic control of public services is rare in a modern democratic state. Instead a number of stakeholders attempt to influence both policy development and its implementation.

On the face of it the pluralist model appears to fit this scenario. The views of many respondents, suggest a different interpretation.

Politics undermines and infiltrates everything and the administrative agenda will control what the commissioning agencies are going to expect of the provider and that includes things like rationing, like managing the resource to the best effect. Like demanding business plans and audits and all the other tools of management.
(Nurse education advisor 1)

Here is a clear awareness on the part of this manager that pressure is coming from above and that, apparently, the professionals have no option but to comply.

An example of a dissenting view is offered:

Given the new Health Service arrangements, the Centre doesn't really have that power any more; it can't really order trusts, and probably has only been able to order general managers, except in certain specific areas, to do certain things. And therefore I think the Centre sees its role - in some things, not in all things - assisted by various publications and advisory groups, as being a way of influencing and changing roles in controlling and commanding it.
(Medical education advisor)

As will be seen later, this view appears to be a lonely voice. The position of this contributor might be significant in understanding why this might be so. This individual is involved primarily in servicing a series of advisory groups, and is consequently removed from direct exposure to the pressures experienced by both the managers and professionals.

Need for control of professions

The imposition of changes on the professional workforce and the rise in importance of management supports instead a hegemonic power model. The professions are seen as requiring much closer control by the management class and legislation is designed to formalise this control through an accountability framework (Salter, 1998). A contribution from a management writer encapsulates this assessment.

Health care objectives tend to cut across those of individual professions particularly in health care where demands are infinite and resources are limited. So decisions have to be made about priorities. Very few, if any, health care areas are entirely the province of a single specialism. However, it is difficult to reach rational decisions when a strong hierarchy is operating. The viewpoints of those less dominant do not get adequate expression. This leads to dissatisfaction.
(Education advisor)

Comments like this recur throughout this work. That is: money is scarce, demands are increasing and old-fashioned professional practices need to be swept away (Alaszewski, 1995). The ideology

of the New Right (Alaszewski & Manthorpe, 1990) has shaped the government's and managers' view of the professions in this decade. However, there is more than a hint that such a transition might not be smooth. This issue of resistance will surface from time to time.

Reaction of professional bodies

I will devote substantial space later on to the issue of professional bodies and their function. Here, I simply ask - how have the professional bodies responded to the pressures outlined above and how can these reactions be understood?

The hegemony of management concepts are seen in the way the professional bodies have adopted these ideas for setting professional standards for entry and maintenance of registration (Watkins, Drury & Bray, 1996). A view from the UKCC is illuminating.

We feel very passionately that in order to support the positive aspects of professional regulation, you need to control both the education that gets you on to the register, the criteria that gets you off the register in relation to misconduct, but most importantly and what we've never tackled before, are the standards for maintaining knowledge and competence and that's what the PREP projects are doing. So very broadly, it's intended to enable practitioners to maintain and develop knowledge and competence and even more importantly it's premised on individual accountability, which is quite a major issue for a large profession which is very disparate.

(Professional body officer 1)

This body has altered its working by making the professional standards more explicit and transparent, but it has also taken on a policing role. The professional ethos is invaded by management techniques. From time to time, warnings surface that importing these concepts can be counterproductive.

The purchaser/provider split is endangering doctors' freedom to make decisions about individual patients on clinical grounds.
(BMA, 1995)

Is this a cry in the wilderness? I will look later on how these tensions are dealt with.

7.2.2 Let the market triumph!

Impact on organisations

The power ascendancy of management within the public sector can be seen clearly in the articulation of management concepts and the commitment to market philosophy.

If the contract required a different standard of service then the commission would have to look quite carefully at rationalising that service to be able to access money from existing resources. So one way it's doing that is to reduce the number of providers or rationalise the number of staff who are providing the service in order to free up money to be able to do that.

(Nurse education advisor 1)

The principal features of the market are present here: competition, lack of long-term stability and the accountants' 'bottom line'. Efficiency is the driving force. The impact on the providers (health care trusts or employed professionals) does not appear as a primary consideration.

Devolution of responsibility through contracting out is nowhere seen better than in the advent of 'mixed economy of care'.

Authorities should bear in mind the need to ensure the development of the social care market, paying particular attention to the needs of minority groups. Given the importance of developing a mixed economy of care, attention should be given to enabling local independent sector organisations to participate in tendering for and managing contracts.

(Department of Health, 1997b)

This extract from a guidance document makes a clear link between the needs of the market and the altered organisation of care. 'Mixed economy of care' signifies a mixture of statutory and voluntary or private organisations being involved in the provision of care. What is the significance of this change? As increased competition threatens the survival of the providers, they may need to compromise on quality standards. Stress on staff is on the rise. Independent organisations may lose their advocacy voice as they are drawn into contractual provision of services (Wistow, Knapp et al., 1994).

Impact on professionals

What might be the consequence of time-limited contracts? In some cases they may undermine long-standing expectations of secure employment, as no unit would be in a position to employ anyone

beyond the guaranteed span of contract-generated income. I noted this possibility at the conference focussing on CPD.

Within medical and dental professions awareness is surfacing that employments may not be life-long. Different types of work, altered roles, will require flexibility and adaptability.

(Field notes - CPD conference 1)

There are further changes accompanying the altered status of the professional workforce, such as the introduction of skill-mix together with the uptake of NVQ qualifications.

Skill-mix

Among the most important changes noted has been the impact on the employment of the existing workforce, as the skill-mix exercise introduces less qualified personnel. This is associated with changing remits of work and responsibilities of current staff. In the case of nurses this has resulted in problems in recruitment as the level of doubt about the future direction of the health service and about future security of employment has increased (Gibbins, 1995).

Note however, that such changes are not always welcome.

From our point of view, it would make sense to have the skill mix or skill transfer ability present with an example of admin staff or portering, taking blood or weighing babies in the clinic. But we have met tremendous resistance when such things have been suggested.

(Human resources person)

The process of change, even if driven from above and seen as rational by the management, is not always straightforward. Hegemony does not imply total control. However, as the respondents noted, skill-mix is here to stay, despite some evidence that it might not ultimately be cost-effective (Jenkins-Clarke & Carr-Hill, 1996).

Rise of NVQs

The market-orientated welfare state requires a flexible workforce, and thus traditional professional freedom needs to be curtailed. This has been augmented by the move towards NVQ (National Vocational Qualifications) -based education that is not controlled by professional bodies and that allows health workers to acquire qualifications that are skills related and not embedded in professional ethos (Burrage, 1994). The performance of NVQ-qualified staff can be measured

against certain occupational standards. The following extract from an Executive Letter from the NHS Executive highlights some of the functions of these standards.

Occupational standards may be viewed as a discrete training issue, but they also cross the boundaries between individual training, organisational development and the management of performance in the workplace. Evidence suggests that occupational standards are being used :

- as measures of individual performance, translating these into departmental and organisational objectives;
- within business plans and the development of risk management and performance management systems;
- for reviewing job roles and as the basis for job descriptions.

(NHS Executive, 1995f)

The potential appears to be vast. These standards allow a significant shift towards an organisational, system view of the service. Individual professionals do not seem to feature in this consideration. Little surprise, then, that NVQ-educated staff are so popular with management, being staff with no allegiance to any specific profession.

7.2.3 The shift of power - the poststructuralist perspective

Next I consider how Foucault's conceptualisation of the impact of societal power contributes to the structure and function of the welfare state. Two concepts are used for this analysis: disciplinary and bio-power. Let's look at an example of how power changes occur.

With the reconfiguration in the community unit to so called LRGs or Local Resource Groupings, these now are not led by professionals, but by general managers which at least in theory frees the professional groups from direct management responsibility which the 'old' neighbourhood nursing approach used to do. The old system with its assumed inefficiencies had to change.
(Human resources person).

How is it possible to explain the changes in policies within the welfare state and the changes in the role of the professions, as shown above? If we accept the proposition that the welfare professions are an integral part of state governance, their role and influence is built on their ability to control the population through the use of disciplinary power (Foucault, 1979a) and bio-power (Foucault, 1979b).

How well have the professions positioned themselves to fulfil this task? Are they fully compliant with the intent of exerting such a control? Two extracts from a policy document throw some light on this debate.

The population sciences of epidemiology, sociology and demography introduce students to the study of groups of people, and how to describe and measure their characteristics as a group. Such disciplines lay little emphasis on the integrity or autonomy of the individual. Rather, individuals are placed into similar age, sex or socio-economic clusters. A scientific process that depends on classifying people into suitable taxonomic groups results in variation between individuals being played down, or "neutralized".

(Royal College of General Practitioners, 1996)

Spiritual pain is deeper and less easily understood than emotional pain because it relates to the meaning of life and personal experience in the individual. The well trained clinician is able to acknowledge the importance of someone's personal search for meanings and to facilitate this process in appropriate ways without either of them feeling awkward or compromised.

(Royal College of General Practitioners, 1996)

If we examine the first extract under a Foucauldian lens, traditional medical care and education emphasise the importance of the key technique of disciplinary power, namely examination. The resistance to such a stance is alluded to rather gently at this point. Nevertheless, compliance with the usual role is not advocated. The second extract makes reference to the technique associated with bio-power, i.e. confession. After all, this what a good listening doctor offers in the safety of the consulting room. Resistance to this technique is not articulated. Why not? A possible answer lies in the first quote - practising individual centred medicine is preferable to an overtly dehumanising, population-centred approach.

The professions need to be constituted as an efficient part of the system for the power linked with this control to be located in their alliance with the state (Gastaldo, 1997). Any such alliance, as Foucault notes (1979b), is inherently unstable and if other, more effective power formulations emerge, alliances shift - in this case, to the hegemonic axis of management and state. I am proposing here that in the current economic climate the professions have been found wanting in their ability to be the principal group responsible for the exercise of disciplinary power. A different 'expert' group therefore emerges to take on the role of governance within the welfare state - management.

7.2.4 Tools of power

I now apply the same power techniques to the professionals. I will look at how surveillance, examination and discipline are manifest in their lives. These techniques of power will be revisited at points where understanding of their function aids the analysis of particular issue, such as the role of IPE.

Foucault's idea of surveillance (Foucault, 1979a) is congruent with the transfer of responsibility from the centre to the periphery with an associated accountability framework put in place. Discipline is one of the principal control mechanisms identified by Foucault. The intention is to produce 'docile bodies' which will comply with the needs of society for efficient functioning. Discipline manifests itself in the process of 'normalisation' whereby standards of the acceptable are set - to separate good from bad, compliant from deviant.

One of the major impacts of introduction of Community Care on social services is more work, they are inundated with paperwork. The basis of contact with clients and other providers is a contractual relationship, they are involved in purchasing care. The need for forms means that their work has a more legalistic basis.
(Team facilitator 2)

Surveillance is continuous: the social workers have to account for their action, and their work is subject to scrutiny. The unspecified manager is ever present and her power is further underpinned by legislation. There is no escape. Personal contact becomes objectified through a measurable (and monitored) contract - the value-neutral measurement rules (Traynor, 1999). Examination with its aspects of surveillance and recording performance in a measurable way is the key technique of discipline.

Direct control is replaced by self-control, self-monitoring, sometimes to standards imposed from above, or sometimes negotiated with the management. This process might take the form of guideline dissemination or promotion of audit. These are designed overtly to help professional decision-making or provide an opportunity to review clinical action, and their authors or advocates suggest that professional autonomy is still paramount. However, this sharing of responsibility correspondingly heightens its burden, so that - paradoxically - freedom of action is diminished. Resistance to such control is not far away.

There are these guidelines coming down, saying you will treat this like this. It's only through an acceptance in the profession itself that things will change. Auditing hasn't taken off as well as it might have done, but it's early days yet.
(Health authority manager)

The implication from this representative of the managerial class is that these methods of self-surveillance will be adopted. Yet again the reference to normalisation is made, whereby the changes will occur as soon the professions adopt different standards of professional behaviour: in this instance, leaving behind their autonomy and complying with management needs.

7.2.5 The factors for change - innovation perspective

This perspective is used to reflect on some of the specific issues pertaining to the context of the NHS changes. It is particularly useful in evaluating how new ways of working are introduced.

As described by King (1990), the list of factors identified during the analysis is consonant with the antecedent factors in the organisational innovation group. Obvious factors include those relating to the quality of leadership, differential perspectives on gain or loss from change, and interpersonal issues. Two further areas deserve mention - namely, the role of the external environment and the culture of the organisation.

While King (1990) pointed out that research evidence for extraorganisational factors is contradictory, it is necessary to accept that external influences are paramount, as has been seen during the re-organisation of the NHS. Despite a degree of autonomy for some of its parts (especially general practice), it is a publically financed service, and thus is dependent on the state which defines its shape and working rules. Granted, even in the public sector not all of the central intentions may be acted on, and interpretation or guidance from above may need to be altered in the light of experience and response from the NHS workforce. Further obstacles to change might reside in the sheer pace of change, as seen by this nurse manager.

What I'm saying is that if you reorganise the health service every year for three years, then it's very difficult to set contracts and then monitor them effectively, because the right people aren't in place. People who worked in the first year to identify training needs and then to indicate those to Region may not be the same managers who are supposed to be releasing people to go on those courses the next year.

(Nurse education advisor 2)

Reorganisations of constituent parts of the welfare state are inevitable. How the directives from above are translated to reality depends on a number of factors, including, as illustrated here, on a degree of continuity within the organisation.

Organisational culture has been shown to be an important determinant of the rate of change. Thus, as showed by Nyström (1990), a culture that is characterised by a fluidity of roles and an ability to accept risks and challenges is supportive of innovation. This has been seen in some general practices which have taken on innovations with considerable ease, such as fundholding, employment of nurse practitioners or opening themselves to scrutiny by patient participation

groups. On the other hand an organisation which has a set of professional groupings that defend their professional boundaries, faces a major challenge in changing such a fragmentary culture.

We have tried to introduce the idea that the LRGs ¹⁶ need to develop a form of action learning, in other words have an opportunity to reflect on how they develop their profile of work and be able to learn as an organisation as they go along.
(Human resources person)

How is any new idea processed? Each idea or directive will be scrutinised for its balance between anticipated gain and loss (Bedeian, 1980). A reluctance to adopt a new way of working will surface if the net outcome of this consideration is negative. I noted this dilemma at a meeting where various pressures on trusts were identified.

The pressures on the general managers' or chief executives come from a conflict between the service delivery needs and contracts and training requirements designed by national training bodies as they can cut back on approval and the numbers of trainees available.
(Field notes - SCOPME meetings)

When there is a need to get the maximum possible contribution from junior medical staff, additional training requirements may be seen as putting a further strain on already overloaded service. In reality, of course, most trusts comply with these changes.

Not surprisingly, a leader's and/or change agent's style was identified repeatedly as a key to success in altering traditional practices. This is very explicit in the following extract:

Leadership is identified strongly as a force necessary for successful change. The educational requirement of the leaders themselves will be conditioned by the role the leader is required to play, and analysis of the skills necessary in support of that:

- Role - a combination of leadership, mentorship and co-ordination;
- Skills - personal, educational, organisational, managerial - very often combined with a career as a practitioner within primary care.

(Calman, 1998)

This view is in line with Rogers and Shoemaker's (1971) proposition that innovators, beside leading the field, are able to enthuse others to follow in due course. If an idea is associated with

¹⁶ Local Resource Group - a conglomeration of financially quasi-independent small units in this community trust

a respected figure, if such a champion for change is able to foreground the advantages of change and 'sell' it sensitively to the organisation, it is more likely that an innovation will take root.

The type of innovation influences the rate of adoption too. Fundholding, for example, was an administrative innovation, and delays in its introduction were congruent with what Damanpour (1990) suggests is an 'organisational lag' of this type of innovation.

7.2.6 Comment

Each of the theoretical perspectives used adds something to the understanding of the context within which the changes in the welfare state, and in the NHS specifically, have been occurring. I return to these insights when looking at the educational scene and the interaction of the stakeholders. There does not appear to be any clash among the interpretations thus reached.

I have suggested that my interpretation of hegemonic power is appropriate for understanding how the welfare state policies have formalised the role of management. The management-state hegemonic axis is seen as a more efficient configuration, compared to the previous situation where the professions held a more dominant role. Foucauldian interpretation offers an additional explanation for the efficiency of the techniques of control of the professions through surveillance and examination. The professions have become 'docile bodies'. Innovation perspective throws a light on the process of change and the factors that influence the rate of adoption. It is useful in highlighting the reasons for the unevenness of change and where resistance to it lies.

7.3 TEAMWORK

The analysis of the data showed that teamwork is considered the cornerstone of successful organisation of health care delivery. A number of areas within the team section of the results do not present any surprises; the current state of knowledge about teamwork as described in Chapter Three and in Appendix One is sufficiently comprehensive to cover most of the issues that emerged during the analysis.

Nevertheless, four areas deserved further analysis: stakeholder perspectives on a need for teamwork, processes that promote or inhibit team function (this is looked at from an innovation angle), the Foucauldian view that provides a critical view of teamwork, and the links between teamwork and IPE.

7.3.1 Stakeholders' views on a need for teamwork

Three perspectives were identified that illuminate the debate on the role of teamwork in the organisation of health and social care. Beside the manager's and the professional's, the patient's voice was also heard, albeit indirectly.

Managers' view

Most contributors in this subgroup appear to suggest that teamwork is important in helping an organisation to achieve its objectives. The boundaries that have evolved around each profession, that delimit its remit and activities, can be counterproductive. The managers talk of patient need, but also of organisational priorities.

As well as getting people to sort out the purposes of a team, it is also necessary to get staff to recognise the importance of the team's business plan - in the sense of a framework for delivering professional practice in a predictable and organised way, meeting all the statutory requirements and making the best use of the skills available and not misusing them. The team approach needs to focus on meeting the needs of the population. Uniprofessional considerations unfortunately often concentrate on professional standards that do not easily translate into delivering a good service.

(Trust manager 1)

The team in this view is a subset of the organisation and individual professional allegiances with their commitment to a professional ethos are seen as unhelpful.

Professional view

Improving patient care through teamwork was on top of the professionals' agenda. They saw a better co-ordination of services and better use of skills within the team as a laudable goal. In this they echoed the management viewpoint. A personal dimension surfaced as well - working within a team could be a challenging and stimulating experience.

You have a group of people who have shared goals, you're not on your own, you're actually working together with their support there at all times. There is space for heresy - and in a real team that is something which is valued. So as individuals within the team you feel that you can express yourself more fully and I believe that it's at the limits of your self-expression that life becomes a true artistry, if you like. It's the things that you wouldn't normally dare to say which is where the breakthroughs are made.

(GP educator 2)

The team as a learning organisation (Schön, 1994) has a number of characteristics that reflect this view. It needs to function on the boundary of the comfort zone, and growth is only possible if there is sufficient trust to challenge preconceived ideas and patterns of behaviour. This represents a modernist view of team function (Rawson, 1994) (see also Chapter Three).

Patients' view

As mentioned before, for pragmatic reasons no patient was interviewed for this work. While it would be perfectly legitimate to do so, I decided to put some limits on my work. However, the patients' perspective was represented mostly by the professionals who spoke in the advocacy capacity.

This whole multi-professional, multi-disciplinary issue arose from the patients' perspective: that if only people could cooperate, work better together, have better understanding of other professions and disciplines, then the patient service would benefit.

(Lay person)

This is a strong plea from a lay contributor for better interprofessional co-operation and communication. The critical view of the current state of affairs is implicit, rather than explicit.

It can be seen that there is an overall agreement in all the principal groups on the importance of teamwork and its value, ultimately for improving patient care.

7.3.2 Achieving teamwork - innovation perspective

Forces for success and failure in teams are predictable. The following categories emerged from the data: altruistic motives, fear of loss of autonomy, support from management and leadership and finally the climate for innovation.

Vested interests represented in the professional groups, who (in the case of doctors) fear an attack on their autonomy or position of power, can be powerful obstacles to the successful introduction of teamworking (McIntosh & Dingwall, 1978). In addition, the attraction of holding on to the defined professional role offers the advantages of societal recognition and status. The competing forces come from an altruistic wish to provide the best possible care for the client group, and this may mean working with other professionals in a collaborative arrangement that demands subsuming one's professional pride. This dilemma is well summarised by a respondent from a

professional organisation, who was able to see both sides of the argument and offered a structured way out.

The issue of professional boundaries is very much at the top of the agenda. There are some mechanical issues, like if you want to reduce junior doctors, somebody else is going to have to do the work, so at one level you say right, nurses and midwives can do this tranche of stuff, and in order to give them the space, then have health care workers come in and fill the gap at the bottom. I actually think that's the wrong way round, I think what one needs to say is that what are the best things for delivering patient and client care and then who shall do it, and that way you get a much more sensible answer to who gets up in the middle of the night to do the IV.

(Professional body officer 1)

From an innovation perspective, an appeal needs to be made to the professional values of the key players (King, 1990). If their attitudes towards improving patient care are predominant, then collaboration will take place. The fear of a loss of professional autonomy was not universal. As seen in the quote above (GP educator 2 on page 183), positive attitudes are present and these need to be tapped for change to occur.

Support from management (Bedeian, 1980) in terms of resources and encouragement are crucial elements in a team's successful functioning. This is especially true if a totally new way of working needs to be introduced, which cannot be initiated from within a team alone. One such example is drawn from a facilitator of the introduction of Community Care.

What helped to introduce a new way of working was the top support for change. This support came from top management in both health and social services. It was essential, thus there is no need to appeal to middle management in each case.

(Team facilitator 2)

In this case two different organisations, with different ways of working, different cultures and perspectives were encouraged to work together. Further, the possibility of resistance from other players appears to have been removed by commitment from the top management.

The case of autonomous teams, such as the core teams based in general practice, is slightly different. While the element of management support is not as important, the issue of leadership becomes more central. Negative attitudes on the part of those who have power or influence, or a lack of understanding of how teams could develop, can be counterproductive.

One practice who really had no conflict as a team at all, who are not working as a team, they are working very much as individuals, they now do meet and there is a team developing, but there's also been a senior partner who is no longer there.
(Primary care researcher)

This respondent noted that a change in a team's configuration, which implies that someone new has moved into a leadership role, has been facilitative of change towards better collaboration. A need for facilitative leadership, as noted in Chapter Five, has been a universal finding in innovation research (King, 1990).

The climate for innovation is an important determinant of success. Being open to new ideas and a willingness to experiment, provides an opportunity to respond creatively to changing demands on the teams. However, achieving a positive, supportive climate may not be always easy, as noted by this group of senior professionals and managers discussing the issues surrounding teamworking:

The group perceived that the blocks to teamworking could be organisational structures and this could extend to problems created by key personnel who may not generate the necessary 'collaborative culture'.
(Field notes - SCOPME meetings)

The complexity of achieving a well-functioning team is apparent to the respondents. Whilst it could be argued that knowledge of these factors is not new (Luthans, 1989), they are nevertheless important and whoever is intent on introducing or improving team function needs to be cognisant of them.

7.3.3 Foucauldian perspective

I would like to suggest that there is a need critically to analyse the assumptions underlying the beliefs, held both by policy makers and practitioners, about the advantages of interprofessional collaboration. It is evident from the review of the literature in Chapter Two and Three that teamwork is promoted with increasing frequency by the policy makers. A Foucauldian analysis offers two contiguous explanations for this attitude - one refers to the efficiency of teamwork, and the second to the control of professional behaviour.

Teamwork is more efficient!

The need for a more efficient care provision has been articulated above within the modernist paradigm. Teamwork has been shown to be an effective way of dealing with complex tasks in a changing environment (see Chapter Three and Appendix One). Devolving responsibility for

planning care and the use of resources should allow better results in assessing and fulfilling health and social care needs. Thus teamwork can be seen as a technology of power which facilitates a more efficient fulfilment of the primary task of the health and social care services, namely, to ensure the productive functioning of the population.

Disciplinary control is exercised through a co-ordinated surveillance and examination of the subjects. This is evident in the move to interlinked team records that allows classification of the service users.

All the information following our team discussions is inputted into the computer which is only accessible to those with a special code. Patient data is kept up to date etc. This is analysed on Tuesdays. Its like an awareness thing. Also there is an 'on call' list which has relevant data. Like we have one entry that says 'do not visit on your own'. There is also the child protection list.

(Team facilitator 1)

In this way the teams assume a role that was the province of individual professional groups. Societal power finds expression in such a reconfiguration of services to achieve greater population control.

Let's control the professionals!

The paradox of team autonomy is linked with increased accountability for the achievement of targets. These can be articulated in the guidelines for team action, in specifying standards for professional behaviour or in the composition of business plans. The control mechanisms of reward and punishment come into play. Reward may take the shape of additional resources and punishment may mean removal of the contract.

Defensiveness will increase unless professionals participate effectively in teams to decide the shape of the corporate activity and then sign up to it and secure it together. Otherwise they will see it merely as resources and control being withdrawn from them.

(Medical education manager 3)

The focus of interest has now moved from individual professionals to teams. Team agreements and business plans provide a means of tying down the professionals to a team effort: the individual professional is dissolved.

Surveillance is also displaced into teams. What appears to be an adoption of a collaborative team culture and collective responsibility for team action becomes a means for individual professionals

to be kept under constant scrutiny by their peers, and to be accountable to the team for fulfilling their tasks. This can happen at meetings when patients are discussed or - one of the best structured examples - when integrated care pathways are used (Curry & Harvey, 2000). These set standards for the progress of a patient with a defined condition.

One way that the standards have been developed and applied is seen for example in the integrated care pathway and also for example the way the package of care for CVA was set up.
(Human resources person)

The key word here is standard, a measure of professional action that specifies the activity of team members. If there is any variance from these standards, this needs to be justified and an individual responsible for this variance identified. The gaze becomes internalised.

Now we can see how professional barriers are challenged, how each individual is made to be accountable to others, how everyone's performance is open to inspection by others. The team assumes the role of a policeman. This nurse manager expresses it very well:

We're continually dovetailing all the time. It's the same if a doctor requests blood cultures, for instance. We need to know why they think the patient is requiring blood cultures, so therefore they must examine the patient beforehand, make a provisional diagnosis and then we can undertake that for them.
(Nurse educator 1)

The power appears to have shifted. The standards of correct professional behaviour are held by the non-medical members - 'we' - in the team, who feel empowered to challenge the doctor's request and make co-operation conditional on fulfilling these standards.

Is there any danger to patients and professionals in establishing professional co-ordination?

From a Foucauldian view, however, there is a danger in the move towards team-based care. Flexibility of roles, and interchangeability of task performers can result in an anonymity of care-giving by teams. This possibility was noted in a group discussion.

Patients can be deluged with people without any clear 'key-worker'. Team practice could sink to the lowest common denominator.
(Field notes - SCOPME meetings)

The contrast between this considered opinion and the following recommendation from a professional body could not be greater.

You should ensure that patients are informed about how information is shared within teams and between those who will be providing their care. If a patient objects to such disclosures you should explain the benefits to their own care of information being shared, but you must not disclose information if a patient maintains such objections.

(GMC, 1998)

How is it possible to explain the differences contained in these two quotes? Perhaps there is no material discrepancy. The first observation ensues from the experience of the participants who have been looking in some depth at what makes teams work well. It is feasible that the author/s of the GMC booklet bore in mind the very same issues and felt moved to set the boundaries or warning signs on the way to full teamworking.

Thus individual professionals subsumed in teams become merely anonymous tools of devolved management. They become the 'docile bodies' (Foucault, 1979a).

And the managers now do it through the use of guidelines and protocols. The culture is not about professional decision-making – it's protocol-based living – and that's the way populations have been so strictly controlled in their lives.

(GP educator 2)

If it focusses on achieving preset objectives, management - like education - can lose sight of the interpersonal side of the professional-client or learner-teacher interaction. The clients or learners have become 'objects' over whom control is exercised with greater ease.

7.3.4 Teamwork and IPE

Inevitably when teamwork is considered by the respondents (or within various documents) a link with interprofessional learning is noted. This brief section will look at two aspects of that connection - teambuilding and the concept of a learning organisation.

Teambuilding was identified as one of the routes to achieve a well-functioning team. For teambuilding to be successful all those involved need to accept the potential impact of changes, as a move toward genuine teamworking will alter professional and organisational boundaries and structures. This would involve a commitment to share and value others' knowledge, experience and skills (Adair, 1987). Teambuilding, however, does not occur in a vacuum. It needs to be located in wider organisational change. An agreement on the elements of such a process was noted in the minutes of an education advisory group.

Development of existing educational provision should occur where this is indicated. Cooperation and collaboration within and between professions should be encouraged. There should be emphasis on developing team working in practice which is fostered throughout the educational process. For example, the Centre can sponsor and support the development of local models including a primary care team and a liaison team, and involve these models in educational programmes. (Health authority education advisory group minutes)

Here the members of the group acknowledge that the current profile of educational provision will need to be adjusted if the goal of team development is considered to be a worthwhile undertaking.

For a team to continue functioning well internally and on the interface with the external world it would need to move towards becoming a learning organisation. It was clear from respondents that the primary requirement in ensuring a team develops in this direction was having protected time for reflection, as well as a willingness to work together and be challenged.

One practice said we will try and have a plan now for our whole practice, rather than as individuals. They actually set up protected time, one and a half hours each week, and would have had a meeting which would centre on education. So it was the primary healthcare team and at the first meeting they actually identified areas that they felt the practice needed to work on. (Primary care researcher)

The first step to becoming a learning organisation (Davies & Nutley, 2000) has taken place, the team members have agreed on a shared objective and have committed themselves to work on achieving these in an exploratory fashion.

7.3.5 Comment

The tension between the two theoretical paradigms becomes apparent. Within the positivist paradigm (represented by the sections on 'need for teamwork', 'achieving teamwork' and 'teamwork and IPE') the team can be seen as a rational answer to the demands for professional services in the current configuration of the welfare state. This rational view of teamwork permeates Chapter Three and the analysis presented above, even if acknowledging the potential obstacles to achieving the working ideal, does not deviate from this line.

The poststructuralist perspective throws a somewhat different light on the promotion of teamwork, and on the role and function of teams. While it accepts the primary need for teamwork because of its effectiveness, it suggests it is a technology of power adopted by the agents of control, namely

policy makers and management. Additionally, teams permit better surveillance of professional behaviour.

7.4 CONTINUING PROFESSIONAL EDUCATION AND DEVELOPMENT - WHOSE AGENDA?

A comprehensive analysis of the CPE/ CPD issues from an organisational and contextual aspect is included in Chapter Four. From the results of the analysis of the interviews, meetings and the documents that refer to CPD, only one component is looked at in detail here - namely the context of the move towards CPD, including management attitudes. Results pertaining to other issues are not presented and discussed further as they have not added new material or insights to the literature review in Chapter Four.

7.4.1 The need for CPD - two perspectives

In Chapter Four three principal reasons were identified for the increased importance of CPD: major changes in the context of the welfare state which put additional demands on professionals; the changing profile of professional knowledge; and the resultant changes in the roles and functions of professional work. These arguments follow a modernist logic, of presenting the world of policy-making and education as a coherent system, where, if sufficient knowledge of the stakeholders and their needs is available, the desired changes can be achieved. Further, adult learning theories have permeated the main arguments about the validity of educational approaches to CPD (and IPE) that foreground learners and their experiences and needs.

A poststructuralist perspective offers another interpretation of the motives and forces behind the rise of CPD. The themes developed in the following sections provides a basis for a further discussion of stakeholder interactions in the next chapter.

7.4.2 The stakeholders view of CPD

I will look in turn at the perceptions of CPD held by all the major stakeholders. What are the reasons given for professionals to attend continuous updating? One important theme emerging from the analysis is the awareness of the changing context within which professional life is played out. Thus it is possible to understand the unanimous support for CPD, even if detailed reasons may vary.

Nevertheless, each stakeholder group understands the need and motivation for CPD somewhat differently.

Managers and CPD

From the management point of view CPD is more relevant as it allows professionals to acquire new skills such as management, communication, and teamwork skills. It also allows individuals to become more flexible, and capable of career change. Within the context of quality assurance of service provision, education becomes linked more closely with performance appraisal. This means that the managers' interest is less on the educational input, and more on its output (Horder, 1995).

The message that went out to practice nurses a long time ago was that you should look very carefully at the quality and quantity of courses that you take and only take courses that are validated and that are specifically of use to your practice.
(Nurse education advisor 1)

Quality assurance is currently an important tool in the management toolkit. In the example above it can be seen to extend to educational provision, and its place in practice nurses' work is implied as well. An interesting contrast is provided by the following observation. Managers - in this case GPs - are creating obstacles to professional updating.

One of the difficulties of course was that because practice nurses were then very much - forgive me for using the expression - the handmaiden of the GP in many instances, although we had given them replacement costs, although we had paid for their course fees, they still wouldn't release them, because they didn't want a stranger in the camp.
(Nurse education advisor 3)

Such a negative attitude could be seen to be counterproductive in the light of the above argument. Surely GPs would want their nurses to acquire additional knowledge and skills to do their job better and to take on new responsibilities? Obviously, interprofessional rivalries muddy the waters.

There is a considerable support from the Government for CPD within the wider context of support for life-long learning (Department of Health, 1996c) and for the establishment of a learning society (Hodgson, 2000). This support can take the shape of an allocation of funds (as was the case with LIZEI money in London), working with other stakeholders in this field and dissemination of supporting documents.

Education commissioners should promote the provision of programmes and opportunities which strengthen links between personal and career development

and management; organisational development, management and leadership; and the enhancement of clinical effectiveness and the updating of clinical competence. (NHS Executive, 1995a)

The agenda, set from the centre, is straightforward. Education commissioners (i.e. the trusts working through educational consortia) need to work together with education providers to make available a raft of programmes that are relevant from a management point of view.

Professions and CPD

Professional bodies, broadly speaking, see CPD nowadays as less of a voluntary activity than a necessity. Motives appear to be twofold - to protect the public from inadequate care and to protect the professions (and the professional bodies) from the charge of not fulfilling their duties appropriately (Watkins, Drury & Bray, 1996). This is part of the remit that professional bodies see themselves addressing - to defend professional autonomy from encroachment by the management class. However, in the process they themselves take on this regulation function instead.

We feel very passionately that in order to support the positive aspects of professional regulation, you need to control both the education that gets you on to the register, the criteria that gets you off the register in relation to misconduct, but most importantly and what we've never tackled before, are the standards for maintaining knowledge and competence and that's what the PREP projects are doing.

(Professional body officer 1)

In the words of this interviewee, UKCC has extended its remit to CPD. It felt obliged to invoke a regulatory framework, as it cannot rely on individuals to maintain their professional development. The threat of sanction, of removal from the register, needs to be visible. Nevertheless, a commitment to holding up the highest professional standards is presented here as a positive force.

The professionals themselves would like to feel that they want to maintain their level of knowledge and skills because they are motivated by an altruistic need, that is congruent with their perception of professional ethical conduct. An extract from a document, setting out a framework for agreement on policy on CPD, reflects this outlook.

Motivation for doing CPD in the health care field

- most CPD is done without any intention of gaining credits towards a qualification.
- individuals are motivated by an interest in their occupation, a desire to keep up-to-date and employable, and to promote their own careers.

most individuals record their CPD principally to meet the rules of their professional bodies and, while doing so, have in mind their own particular needs and ambitions.

(Academy of Medical Royal Colleges, 1998)

Motives enumerated here are complex. Beside altruism, they include pragmatism - the need to comply with professional regulation, but also to keep a keen eye on their future. A cynical (or realistic?) view finds expression in the following contribution.

People were very anxious to get their brownie points and so quite a lot of the attendance would have been from people who didn't actively select the course for its characteristics, but had to find something to do.

(GP educator 1)

Problems with the PGEA system are well known, as it unfortunately can encourage the negative behaviour identified here (Pitts & White, 1994).

The educators and CPD

Those involved in organising CPD have an uneasy task. By necessity they still work , in most cases, in the market place and thus have to provide varied and interesting educational fare (Singleton, Smith, & Hornung, 2000). Yet a number of them do subscribe to the construct of the professionals who may need to be helped to see the advisability of keeping up-to-date.

GPs in the region are busy, so there is this constant task of trying to help people to see that however busy they are, the tasks of general practice are very difficult and there are modalities of learning which will help them to devote themselves to, on the one hand to give better services to that patient, on the other hand to feel better through feeling less de-skilled, more on top of things.

(GP educator 1)

The altruistic view of this educator comes across well and is consonant with what I called a cynical view expressed above. He sees the need to change GPs' outlook, and his role is to help them to recover professional pride and the responsibility for maintaining high professional standards.

7.4.3 How is control operationalised through continuing professional education? A poststructuralist view on CPD versus adult learning theory

The focus in this polemic is on professional competence. Why is there such an interest in assuring professional competence?

A need to limit professional autonomy

As demands on the system of care delivery become increasingly stringent, the freedom of professionals' action has to be curtailed, since the unpredictability of their behaviour can lead to inefficiencies (Salter, 1998). CPD thus becomes one of the technologies of power adopted by the governing hierarchy.

The professionals are seen as not necessarily choosing the 'right' type of learning or having to be coerced into keeping abreast of current developments. Also the organisational requirement is given precedence over individual freedom of choice.

The whole idea of how one copes with the tension between professionals who want to define their own learning needs and develop in their own way (if they want to develop) and the organisation needs which may be or is linked with what the organisational pressures are, can be dealt with, for example, by contracts.
(Human resources person)

This tension between individual development and organisational needs informs much of CPD debate (Brookfield, 1986). Freedom of choice, an intention to maintain professional autonomy in this regard, is perceived as counter to the organisation's needs, and may need to be regulated.

Technologies of power

Foucault suggests that the key mechanisms of societal control are observation, examination and normalisation (Foucault, 1979a; 1979b) (see Chapter Five). These mechanisms are examined in relationship to CPD, but similar arguments are returned to briefly when considering equivalent issues in IPE.

In Foucault's formulation (1979a), Panopticon is a metaphor for surveillance and the transfer of responsibility for maintenance of discipline to the subject. Knowing that one is potentially under surveillance, but not knowing when that gaze may be turned on one, forces the subject to internalise the rules of obedience. This can be seen in education when information about

individuals is collected, collated and classified. Such a categorisation in fact restricts individual freedom, as students are manipulated through allocation to categories. As the category of a 'good' student becomes more explicit, responsibility is transferred more towards the students themselves.

We have an appraisal and you have from the previous year got your plans for the current year. You see if you achieved these things and you then have to make another learning contract or a practice contract for the coming year and usually it is about good practice and keeping up-to-date.
(Midwife educator)

Not all the professionals, however, are blind to this invasion of their professional self-determination.

I do have an obsession with (this tendency of) measuring things in educational terms as well as in professional terms. And really we test and we test and we test. And we say "You have to do this many hours in these areas", or we say, "You have to pass this test and get that number of correct responses on it", and I have a problem with that whole philosophy, because I don't believe it tells you about the value-added side which is the more important side.
(GP educator 2)

The trend to exert an increased control is, nevertheless, inexorable. The move towards revalidation that has taken root in the nursing profession, and is being considered by the medical profession for introduction by 2005, is a clear sign of normalisation and standard-setting.

Portfolio-based learning is a good example of the surveillance trend in continuing education. Collecting evidence of one's competence and making it available to external scrutiny forces the professional to be their own supervisor, as they have to decide what evidence is needed to fit in with the requirements of the revalidation body.

There is a portfolio and also a need to do five days of learning every three years. They have to demonstrate that they have learned some skill that is relevant to their field of work. So it actually forces them to think quite carefully about what's relevant to their practice and start to think about what they need to learn.
(Nurse education advisor 1)

An adult learning perspective would suggest a more benign interpretation (Knowles, 1990 a). Having responsibility for one's own learning, for evaluating the evidence of such learning, allows a more co-operative approach to the setting of standards. Further, a space is available for learning from one's mistakes and taking corrective action.

Now they (nurses) actually got to evaluate the learning for the portfolio and say what it has done to change their practice so there's an element of reflection coming in. So they're beginning to think more academically about what they do instead of more practical about what they want.
(Nurse education advisor 1)

The Foucauldian view challenges this interpretation, however. It asks: what is the motive behind such learning approaches? Is it to empower the learners for their own sake or - more likely - to make them more compliant with the system's needs? The language employed here - 'have to' and 'forces them' - provides a clue. Coercion is the order of the day:

The system of education that expresses a preference for conforming behaviour ensures that an individual becomes a case. Thus governance becomes easier. As a result of the current focus on competencies each individual becomes a number in the bureaucratic world, a commodity of the market and the efficiency-orientated enterprise. Normalisation has an insidious impact on the relationship between learning and the individual - it removes the personal aspects of learning and assessment by making them appear to be value free. As Usher and Edwards (1994) suggested (p103): 'The significance and power of normalisation is precisely that it appears to be neutral.' Neutrality resides in reference to objective scientific knowledge, and in appearing to develop and support the natural gifts and needs of individuals.

The competency approach has a powerful appeal, as its argument - that it is in fact a form of a progressive educational practice - is articulated in a humanistic language. Thus elements of student-centred learning, freedom of access, extending the learning to different sites, and APEL are discernible within this approach.

Competencies rather than curricula. Learning methods more adapted to work patterns - learner-centred, flexible and transferable.
(Region education advisory group minutes)

The adult learning language ('learner-centred') is associated here very closely with the management language ('adapted to work patterns' etc.). The net result, however, is the opportunity for a more exact exercise of power over the behaviour of the learner. This foreshadows the analysis presented in the second half of the next chapter about the interpenetration of discourses.

7.4.4 Comment

This section has continued the debate between adult learning theories and the postmodern critique presented in Chapter Five. The poststructuralist interpretation of CPD offers a more systemic view

behind its use as a technology of power. Adult learning theories can only point to problems in trying to achieve effective learning - while their perspective is critical, the poststructuralist tries to find ways of supporting it. It can be seen here how adult learning arguments can usefully be employed by the managerial class in its need to respond to changes in the world of professional work. If control appears to be couched in supportive terms, it might be more acceptable to the learners.

This somewhat polarised debate, of course, does not present all the possible arguments within CPD. There are sufficient concerns from the adult learning point of view (as already outlined in Chapter Four) about current approaches to CPD that are inefficient or potentially counterproductive. Similarly the competency movement has been subjected to a critical analysis in the same chapter. Nevertheless, the discussion here provides a useful building block for the analysis of stakeholder behaviour and discourses presented in the next chapter.

7.5 WORK-BASED LEARNING

Work-based learning (WBL) is clearly an important, even if minor, theme within this work. It is worthwhile spending a little time examining this phenomenon as it is characteristic of the changing face of continuing professional education. Who are the stakeholders in work-based learning, and what are the arguments for it? To answer these key questions, the analysis takes on policy and adult learning perspectives. Not surprisingly, a brief poststructuralist coda takes a more inquisitorial look at the potential problems with the concept and practice of WBL.

7.5.1 Stakeholders in WBL - the policy perspective

Support from the Government has been substantial (McHugh, Fulton & Saunders, 1996) as it has responded to pressures from the employers to facilitate the development of a skilled workforce. The work-place has become more complex with, for example, more pervasive use of information technology and a commitment to quality assurance, that demands an acquisition of situational knowledge. Such a knowledge is not abstract any more, it needs to be relevant to an actual situation.

The advantages of WBL for managers seem to be that it is less expensive to run, even if more expensive to set-up initially, and they are able to exert better control over learning by making it relevant to the required roles and skills (Portwood, 1996). Managers prefer it, as it entails less time

out of work. One of the emerging modalities is WBL being organised in partnership with a university. Of course, such relationships are not always straightforward.

Specialist tutors have been maintained and an on-site satellite exists in the hospital. There are problems with this because of separation from the higher education set-up in the university. Keeping specialist education will be difficult if the teachers are away from clinical work. Integrating clinical and teaching responsibilities is difficult. The economic demands require keeping trainees together in large groups.

(Nurse education advisor 4)

A number of tensions are highlighted here that might have a negative impact on learning. Will the specialist nurse tutors be able to maintain their close awareness of clinical problems, if they do not get their hands dirty? And the drive for efficiency has invaded the world of education as well, with a real possibility that learners will get less personal attention.

The institutions of learning have recognised the importance of WBL by beginning to work together with employers (Brennan, Kogan & Teichler, 1996). Initiatives, include accrediting experiential learning and enhancing work-based educational activities. Other, less high-tech, initiatives can start more from the bottom-up and depend on the enthusiasm of the organisers and the participants.

Somebody set up a scheme for reciprocal practice visits which would be a PGEA approved, while the GP would go to the practice, sit in on the surgery and then talk to the practitioner about various things including the partnership, and the individual and the partnership and the demography of the practice and then do the same back, and only about half a dozen people have done this so far.

(GP educator 1)

This informal set-up relies on voluntary participation. Nevertheless, there is a possibility that it could become institutionalised and run by the GP tutors.

Professional associations have promoted this modality as being particularly suitable for CPD (The England and Wales Working Party of Regional and Associate Regional Advisers in General Practice, 1989). At the same time, there is an awareness that they have to look critically at its design and use (Fish & Purr, 1991). There is a danger, especially during the post-qualifying stage, of WBL not having adequate educational support in the work-place due to inadequate training of supervisors and general service pressures.

As I noted at a conference on WBL, professional learners seem to express positive attitudes towards it:

Advantages for students include: recognised qualification (gold standard is an academic qualification), convenient time and place, relevant to work, possibility of gaining academic recognition for work done and the content of job role, and employer would recognise professionalism.

(Field notes - WBL conference)

All the stakeholders see, with some reservations, the advantages of work-based learning. But how has WBL arisen? I would like to suggest that the move towards work-based learning came from the management. The fact that it now features prominently in management thinking is highly relevant. An example of how policy is made is extracted from the minutes of a regional group.

The Consortia have budgets for education in Primary care and aim to push accreditation of work-based learning in the Primary Care context.

(GP postgraduate education committee minutes)

A decision is made here to allocate funds to WBL; and having control over finances gives the education purchasers a considerable leverage. This fits in with the previous proposition, that the power in professional education has shifted towards the management class.

This situation is characteristic of the hegemonic model of the policy process.

7.5.2 Why work-based learning? Adult learning theory perspective

The educational reasons for supporting WBL are the opportunities it offers for enhancing the relevance of academic learning and serving as a stimulus for professional development. Further, it plays an important role in a professional's transition from an academic learner to a practitioner. Theoretical learning is modified through its application and reflection-in-action, and new insights accumulate from experience (Schön, 1987). Achieving the ideal of adult learning may not be easy - old patterns of learning die hard.

Another potential failure of the approach to the organisational development has been shown in the idea that the teams need to develop a form of action learning, in other words how they develop their profile of work and be able to learn as they go along. When the team managers were given a choice of what kind of learning they would like for themselves or their staff not surprisingly they went for traditional rigid modular learning that takes people away rather than more adult oriented work based learning.

(Human resources person)

This respondent is an advocate of the adult learning approach, but is also a manager. Is it possible that action learning, resulting in changes in patterns of working, is seen as a threat? Yet action learning has gained in popularity in recent years (Annandale, McCann et al., 2000). The argument

is simple - learning prompted by problems identified in practice is likely to be very effective (Green, Gunzburger & Suter, 1984).

7.5.3 Is work-based learning such a benign enterprise ? Poststructuralist critique

What is the potential impact of work-based learning on the learners? Closer involvement of the employers in the planning of their staffs' learning carries with it explicit and implicit control. Work-based learning in most cases will be precisely orientated towards the employers' needs, giving less freedom of choice to learners. At times, the intention of increasing the degree of control, is surprisingly manifest.

Vocational training courses have mushroomed for specific developments as required by particular professional groups. Instead of providing for these through study leave, there is increasing emphasis on education which is in-service and on-the-job, through short, flexible, service-needs related provision.
(Health authority education advisory group minutes)

An interesting shift of power can be observed here. The management accepts the need for professional development, the shape of which is designed by the respective professional bodies. However, the management takes over at this points, specifies the content and its location. Such an action challenges the autonomy of professions - disciplinary power is exercised over them. This observation is consonant with my analysis of how professions are becoming 'docile bodies'.

In addition a surveillance mechanism comes into play - through the location of learning, a not infrequent use of work-based mentors, and team learning.

A debriefing period is always necessary following any critical event, simply because the members of the team need to know what happened. They need to know whether the initial treatment was effective; they need to know what the prognosis of the patient was; they need to know how well they did. Unless you reinforce team members of how well they responded, whether their approach was coordinated, what the outcomes of it were - you're just going away without any information and you are not actually getting any reinforcement that you need. Because if there was an error or an error of judgement, one should be able to sit down and say well maybe we should be looking at it from another viewpoint.
(Nurse educator 1)

Learning becomes identified with the aims and objectives of the management and mentors take on the role of the facilitating interface between the staff and the organisation. Team learning has the same features as team working. Uncovering individual vulnerabilities, sharing through confessing one's educational weaknesses, institutes team control through surveillance.

7.5.4 Comment

The tension between the adult learning and poststructuralist analyses is clear. The former sees work-based learning as usefully combining the learning process with an opportunity to test out such learning and make learning more relevant. The Foucauldian angle, however, suggests that the effectiveness of this modality of learning renders it a useful tool for controlling professionals.

7.6 INTERPROFESSIONAL EDUCATION - THE NEW KID ON THE BLOCK

Two broad new categories concerning IPE emerged during the data analysis: the need for IPE, and controlling professions. Other issues are not reported on, as they do not add materially to the literature review.

The perspective adopted here is critical, as opposed to the more neutral one presented in Chapter Three. As Pirrie et al (1999) argue, it is necessary to analyse the assumption that IPE is a 'good thing'.

7.6.1 The need for IPE - modernist perspective

Three perspectives - hegemonic power, adult learning theory and the poststructuralist perspective - are brought to bear on the wider issue of IPE, and its role and organisation. The first two, as they belong to the modernist camp, are employed here. The poststructuralist viewpoint is presented in the next section.

The power perspective

In addition to looking at how IPE can be seen to contribute to changes in the power balance vis-a-vis the professions, I will here explore the role of its evaluation.

Chapter 4 described the slow beginnings of IPE, both in policy terms and in establishing it as an accepted part of professional education. On the surface the pluralist model appears to fit the picture of multiple stakeholders and their roles in developing this aspect of professional education. However, the situation has changed in the last few years.

As suggested earlier, the evidence of hegemonic power wielded by the management class appears in the promotion of teamwork, and in the focus on the importance of continuing professional

education linked to the needs of the service. Similarly, interprofessional education, by virtue of its challenging the accepted boundaries of professional designations and roles, and because of its intent to promote interprofessional understanding and co-operation, is a natural instrument of control. Awareness of this trend was articulated during a CAIPE seminar:

Dr T outlined approaches to interprofessional learning at undergraduate and postgraduate level. He noted that professionalism, which includes expert, managerial, practical and reflective abilities, is increasingly questioned. In the future, a more generalist perspective to problem solving was likely, with a move away from specialism.
(CAIPE minutes)

The comment above takes the argument further. IPE has a potential ultimately to dissolve professional boundaries (Francis & Humphreys, 2000), and give rise instead to a generic worker. This resonates with my comment made earlier in the chapter, that other new arrivals on the professional landscape, namely the introduction of skill-mix and NVQs, can also be seen as part of an anti-professional drive.

Yet another important motive can be discerned. The concept of a mysterious professional knowledge, that can be held by an individual profession, and that is accessible only through a rigorous process of uni-professional education, is debunked during the IPE encounter.

The courses we put on are for everybody, regardless of whether they're a consultant, health care assistant, dishwasher, or whoever it may be. Say, for instance, I want a basic life support course. I will get physiotherapists, occupational therapists, secretaries from the typing pool, personnel officers - anybody - regardless of their path. We make the assumption that the individuals know nothing, so they are all trained to the same standard.
(Nurse educator 1)

Of course, it has to be accepted that professional boundaries have been moving. Work undertaken by junior medical staff is done nowadays in many instances by specialist nurses (Greenhalgh, 1994). A number of GPs' tasks have been taken on by practice nurses (Jenkins-Clarke, Carr-Hill et al., 1997). This inevitably has meant that these nurses acquire knowledge and skills that have been hitherto the province of the medical profession.

Interprofessional education in the cases described above is seen as a reasonable tool for the management class to employ to achieve its aims of providing a more responsive and efficient service.

Evaluating interprofessional education

What are the reasons behind the moves to evaluate IPE? How can these be understood? Before seeking answers to these questions, I want to observe that similar views were widely held about a need to evaluate IPE. The following two extracts support my assertion.

The group felt that suitable research should be undertaken because, as they noted; there is lack of an evidential base as to the efficacy of multiprofessionalism.
(Field notes - SCOPME meetings)

If the intention is to promote multiprofessional education surely it would be better to tackle that promotion rationally gathering experience and evidence and making an appropriate case for it.
(Professional body officer 2)

A call for evaluation of IPE comes within the context of a move towards evidence-based care and purchasing that has become central to the thinking of management and clinical staff within the last ten years (Evidence-based Medicine Working Group, 1992). In demanding compelling evidence for the use of scarce resources, the ideology is a rationalist one. A need to ration moves a political or management decision to a medical arena, whereby scientifically trained professional staff will be committed to use the best available evidence to guide their professional decision-making. Wide acceptance of this idea within the medical profession is evidence of its hegemonic nature.

The debate within the educational establishment has been lively over the last few years. Hargreaves (1996) argued that expenditure on research does not appear to improve the quality of teaching. Further, few of the research findings are generalisable and the results themselves are not communicated to the practitioners. His critics counter that teaching is a personal matter, and that the process of learning, including the interaction between learners, teachers and the subject matter, is unique in each situation (Hammersley, 1997). Their argument is that research should be used to gain a better understanding of these interactions, rather than to identify the most cost-effective teaching practice, which they argue is in any case difficult if not impossible to do.

View from the adult education angle

In Chapter Four's comparison of the potential advantages and disadvantages of IPE, the perspective taken was a rationalist, modernist one. It built on the reasons and evidence that appear to result in a fine balance between these arguments. However, it was basically in sympathy with the idea of

IPE, which in the current complex organisational context of care organisations, is an appropriate educational enterprise for making teams function more effectively.

Further arguments for shared learning come from an understanding of the learning process itself. A positive regard for others within the shared learning setting provides an opportunity for such respect to be carried over into the working world. It could help create tolerant attitudes towards others in times of stress. Learning, especially in the work-place, can permit teams learning together to develop a common culture that is flexible and responsive to organisational aims without losing the team's individuality and identity.

Perhaps not surprisingly, many respondents expressed their view of the value of IPE in 'adult learning' terms:

Different parts of the system had different knowledge of Community Care - SWs more, health workers less so. Some GPs were keen to be involved, but others much less so - this was linked with their view of their role. How did we organise the team? We started with a problem solving group of GPs and managers meeting to discuss the results of the research I have done and trying to address the problems uncovered. An example could be the lack of knowledge of function and structure of social services department by GPs.
(Team facilitator 2)

Working and learning together are bound inextricably. Problem-solving also allows active learning, which can then be carried over to professional practice (Miller, Ross, & Freeman, 1999). Respect for each other permits a much needed change in preconceived ideas and established patterns of behaviour. An ability to work together can then be built on these foundations.

7.6.2 The Foucauldian perspective - IPE as a tool for control of professions

The two concepts articulated before are relevant to this discussion - surveillance and normalisation (Foucault, 1979 a). Surveillance is intrinsic to the design of IPE: suddenly a profession is open to scrutiny by the other, and none of the supposed specialness of its knowledge, decision-making and conceptual framework is hidden anymore. The base of such a professional definition can be questioned and the professionals are open to a critique of their actions, thinking and attitudes. A very stark picture is presented by this interviewee.

Multi-disciplinary learning is very difficult. It's down to the lack of mutual respect. If you advertise such an event, GP's don't come. If you don't mention who it's for, GP's will come. If you advertise it for 'practice nurses and GP's', more practice nurses will come than if you'd advertised it for 'practice nurses'. You can

sit in the room and see why - you can see a practice nurse asking a question, and you say, oh god, what a stupid question. On the other hand there are just as many questions that are quite illuminating, and every body wants to know the answer to. A GP is just as likely to put his hand up and ask a stupid question.
(Health authority manager)

Here the scrutiny works both ways. While it may seem that the primary focus is on practice nurses, GPs themselves can be found wanting not only by asking 'stupid questions', but also by admitting the limitations of their knowledge. And this ignorance would not have become apparent if they had not attended an IPE event.

Normalisation appears as the equalizing factor. Is it not useful to have an agreed set of professional behaviours, ethical standards and conceptual frameworks that can determine professional action across the board? Deviant behaviour and thinking can be observed and challenged within a shared learning setting. Pressure can be brought to bear on individuals to alter their response patterns. Two quotes above illustrate this argument admirably (Nurse educator 1 - page 201 and 203). In both cases a desire for better, more repeatable, professional behaviour determines the organisation of learning, be this reflective learning in the first example, or a more fixed piece of educational input in the second.

It is not perhaps surprising that normalisation as a concept has penetrated policy-making in professional bodies. An example of how this can be made acceptable follows:

Effective clinical teams should be prepared to test themselves against others providing similar care, to see where they stand and to learn from this. This testing can be quite informal - for example, through visits, discussions, and comparing results with colleagues. There may also be a more formal audit, involving an external review leading to accreditation for training.
(GMC, 1999)

The argument in this extract is based on a presumed wish to learn and improve. It builds up the case in stages, ending with a suggestion for a formalised audit. As remarked already, audit is par excellence, in Foucauldian terms, a tool for examination. Having set the standards, the professionals and their action are made available for inspection.

7.6.3 Comment

In this section a number of propositions were advanced on the status of IPE. While at times some interpretations of the evidence might appear incompatible, I would like to suggest that contrasting perspectives are needed in this new, emerging field. This will allow the interested parties more

clearly to identify their ideological positions, and to learn how to interpret the actions and thinking of the 'other'.

How can the rise of IPE and the role of the state be understood? I have proposed that the dominant class, within the hegemonic power perspective, is the managerial class. It is used and supported by the state to control the tendency of the professional class to spend money without adequate consideration of the needs of the economy at large. IPE is then the means to that end - of controlling the powerful professions.

A contrasting but complementary perspective on the role and need for IPE is offered by the poststructuralist and adult learning theories. The poststructuralist view appears to support the picture described above, in which such learning allows close surveillance and normalisation of the powerful professions. Thus control is displaced down to the learning encounter and the standards required by the management are enforced through that encounter. The adult learning perspective seems to fall into the modernist camp by suggesting that IPE can be an effective way of dealing with the complexities of care that demand co-operative working.

7.7 SUMMARY

In this chapter I have analysed the context components that impact on interprofessional education, namely changes in the NHS and the welfare state in general. I have noted how teamwork together with CPD and IPE has become a central concern of policy makers and managers. The reasons for this shift were presented from the contrasting perspectives of power and change. Two arguments emanating from each of the two broad theoretical perspectives were developed. The first set of perspectives from the positivist camp include the hegemonic view of power, innovation and adult learning theories. The argument presented is in the tradition of enlightenment - progress is a necessary and positive force. Consequently society needs to alter the functioning of its institutions to make them more efficient in the face of increasing demand and economic retrenchment. I have suggested that power has shifted away from the professions to the managerial class, which foregrounds teamwork, CPD and IPE as means of achieving the aims of a more effective workforce.

The second view, based on Foucault's interpretation of societal power, accepts that as society becomes more complex new and effective technologies of power become adopted by the governing class. In the case of the professions, these technologies are the same - teamwork, CPD and IPE. In contrast to the positivist view, the need is for a greater control of the population in order that it can

function more efficiently, and for a closer control of the professions so they can fulfil their role as instruments of disciplinary power and bio-power.

This discussion provides a basis for the analysis of the role and behaviour of individual stakeholder groups that follows in the next chapter.

8 CHAPTER EIGHT - DISCUSSION: STAKEHOLDERS IN CONTINUING PROFESSIONAL DEVELOPMENT AND INTERPROFESSIONAL EDUCATION AND THEIR DISCOURSES

8.1 INTRODUCTION

In this chapter I address the last of the four aims of the thesis, namely:

To **investigate how IPE and CPD feature** in the thinking and practice of key players, who are identified as policy makers, educators, employers, and the professionals themselves.

This chapter divides into two sections. The first uses the theoretical frameworks from the positivist stable, while the second section employs the discourse analysis method in the Foucauldian sense. As in the previous chapter these perspectives are used to obtain a complementary view with the intent of enriching the understanding of this developing scene. The analysis in this chapter builds on the work presented in the previous chapter which in a more general way looked at how changes in the welfare state and the increase in the importance of teamwork, CPD and IPE, can be understood.

The work presented in this chapter breaks new ground. While policy-making and power relationships in the welfare state and higher education system have been analysed before, no such work exists (to the best of my knowledge) that relates to CPD and IPE.

The list of stakeholders identified in this research is given in Table 8.1. First, however, a comment on my justification for merging in most instances in this chapter the discussion on CPD and IPE.

8.1.1 Shared concerns in CPD and IPE

<p>The manager group:</p> <ul style="list-style-type: none">- DoH or more precisely the NHS Executive,- commissioners of health care or the health authorities,- providers of health care (various health care trusts and GPs). <p>The intermediate group:</p> <ul style="list-style-type: none">- regional educational structures,- local educational consortia and boards,- education managers,- purchasers of education (these include health care providers and the professionals themselves). <p>The professional group:</p> <ul style="list-style-type: none">- professional bodies,- professionals. <p>The education group:</p> <ul style="list-style-type: none">- education organisations,- educators as individuals.

Table 8.1 Stakeholder groups

My justification for bringing together CPD and IPE under one umbrella is that both of these educational modalities have been until recently on the margins.

CPD, or CPE as it was until a few years ago, is a primary concern of the professionals themselves. However, with rapid changes in the knowledge production of modern science, it became clear that haphazard, disorganised ways of keeping up-to-date are insufficient. This (as has been shown in Chapter Four) has been recognised for some time by the professional bodies themselves, who have tried to bring in various mechanisms to ensure the continued ability and competence of their members.

IPE poses a different picture. A marginal enterprise until recent years, it has since seen a considerable increase of interest from all the stakeholders. The reasons for the rise of its importance have been extensively rehearsed - but the key for our consideration here is its supposed ability to improve teamwork and facilitate control over the powerful professions.

Thus we have two fields of education that have been marginal until now, but appear to have gained in importance in recent years as a means of ensuring a better quality of professional performance.

CPD and IPE cannot be left to chance, as they provide additional tools for equipping professionals to fulfil their function within the state apparatus.

Structure of the education system and policy-making process

As already noted in Chapter Four, the education system concerned with CPD and IPE is less structured and is dispersed over a number of providers. Further, a considerable amount of it in primary care is under much closer control by the intermediate group. In the case of GPs the major providers of CPD are commercial companies and GP tutors. The GP tutors currently relate to the postgraduate GP structure, which is a part of the intermediate group. In the case of other primary care staff a substantial amount of the educational provision emanates from the health authorities or the community trusts, albeit under control of their educational advisors. The higher education sector overall plays a relatively minor role in this respect.

The implications for policy-making for CPD and IPE are clear. Where policies exist, they are not exclusively the product of the independent education sector. If that were so, this sector would try to maintain some intellectual coherence across its education provision. Instead, I argue, policy-making is a part of the governance process of the manager and the intermediate groups, and thus any policies are bound to reflect their motives. However, reference is made to explicit or implicit policies as far as they can be discerned from the education providers.

8.2 AN ANALYSIS OF POLICY-MAKING AND POWER RELATIONSHIPS - ANALYTICAL FRAMEWORK

The structuralist framework of power¹⁷ (as developed in the Chapter Five) proposes that there are different loci of power represented by the stakeholders as identified within the data. It builds on the proposition outlined in the previous chapter, which talked in more general terms about the stakeholders in CPD and IPE. Two somewhat contrasting views of the location of power were offered - the pluralist view suggested that there is a more equal distribution of power, while the hegemonic view identified the managerial class as holding power on behalf of the state. I show that in the end a more composite theoretical framework needs to be used, one that incorporates different explanatory strands, to cater for the complex policy-making and implementation situations analysed in this work.

¹⁷ Power is conceptualised here as the ability of a stakeholder to influence the behaviour of others, of having an influence on policy-making or decision-making.

Attention now turns to the individual stakeholders, identified during the data analysis as the managerial group, the professional group and the education group. An additional intermediate group, articulating the communication between these, emerged as a further important part of the network. These groups are looked at in turn. In the following sections I will look at the role of stakeholders, their interactions, and the issue of power that is central to such interactions. The issue of power is examined in some detail, looking at the motives - including their perception of priorities - of various stakeholders in using power. I will also look at how this power is operationalised : what tools are used and how initiatives are taken.

Part of the implementation of power involves the creation of a perspective of the other players or of part of the system. This meaning creation is central to understanding individual stakeholders' justification of their actions. How this is manifested in the use of language or discourses will be addressed in the second part of the chapter.

8.2.1 Power and stakeholder interactions

The interactions between stakeholder groups are complex. Each of these has a stake in the process of developing an idea, its implementation and dissemination. The power, respect, and standing of each of these players within the network will influence how their work and efforts are accepted and processed by the educational system.

It is interesting to note that data analysis put together the state and various manager groups. Whilst the intermediate structures were identified as a separate group, they do share with the manager group a number of characteristics. These include structural identification with the management/ employers and functional integration - since their role is translating the intentions of the employers to reality. The implication is clear: this formulation seems to favour the hegemonic model of power much more than the pluralist one.

Policy-making

However, the pluralist model may apply to some of the aspects of policy-making. The key function of a stakeholder is essentially an involvement in the change process. This may mean a wish to maintain the status quo or to influence change in a specific direction (McCann & Gray, 1986). Policy-making both at the national and local level is under the influence of the competing interest groups (see Chapter Four). In the case of IPE and CPD these are the key stakeholders - namely professional organisations, management and educators. I am not suggesting that these stakeholder

groups are homogeneous. Quite the opposite: sometimes there may be competition between the members of the same group or co-operation between the members of different groups (Johnston, 2001). This would be determined by their actual need. I will look at some examples of how policy is shaped, both during its development and implementation, and what influences the behaviour of different subgroups.

Thus for example the professional organisations involved in the policy process will behave according to their designation or constitution. In the case of a representative organisation, such as the BMA, they will have the interests of their members at heart, while in the case of a regulatory organisation, such as the UKCC, they will want to mediate between the state and the professions. A good example to start with is a reference to the UKCC's process of developing an updated system of registration.

We consulted with the profession at every stage, we had regular meetings with our colleagues in Government in all four countries of the UK so they knew what was coming, when we'd consulted with the professions, we'd listened to what they said, the first scheme that we put out was very very rigid, and we turned it round, we made it much more flexible, we moved away from the notion of having approved courses, we moved away from the notion of having clearly hierarchical sections of education and it was much better, so I think by the time we put it to Government, they were quite willing to agree it.

(Professional body officer 1)

Policy-making appears to originate within the regulatory body, yet nevertheless this body felt a need to work closely with the government. As I will argue in detail later, the UKCC proposed this system to ensure tighter control over the CPD of its members. Even though it might seem to be a matter of professional standards, is in fact a part of an overall government agenda of professional control. Even so, the key point here is that such a consultation process implies a recognition of the multiplicity of interests, and also the need to involve the key constituencies in the process of change.

The advisory group chosen to represent the various processes and stages in policy-making is another case in point. It has the function of advising the Secretary of State for Health on postgraduate education (medical and dental) matters and has representation of all the stakeholders on its committees. These bring their factional interest to bear on the formulation of important policy documents. At the same time they have to be sufficiently mainstream to be acceptable to and have any impact on all their constituent groups and the government. The group follows an independent route of developing those documents and reports that are targeted at decision makers in the NHS. To this end it consults widely, gathering evidence from representative groups and

stakeholders. In the case of IPE and teamwork evidence was obtained from educators, managers and the senior members of professions.

The advisory group - and with the tacit agreement of the Department - it is really looking to try and stimulate and facilitate change without necessarily having to be a statement of intent from the centre. That is to say that if there is something beginning to develop and if we work on it and produce advice about it, the resulting work can be disseminated so that it can be used as useful information, guidance, whatever, stimulus material, debating matter - anything you like really - that actually makes things move ahead locally and regionally and wherever, without there necessarily being that edict from the centre saying "This is a good thing, this is what ought to happen".
(Medical education advisor)

Two points need to be made here. There is some resonance to the situation with the UKCC, in that a policy that might be deemed by the government to be 'a good thing', can nonetheless be developed without any direct impetus from it. The second point concerns the implementation stage. Ambiguity, or rather the inadequacy of the policy process, is inherent in this group's designation: it is advisory only, its brief does not extend to implementation. The implementation function is taken up by the interest groups themselves. In this respect a feature of innovation theory (Hultman & Hörberg, 1995) is relevant - the process of consultation allows ownership of the idea to be developed within the diffuse system of professional education. Incidentally, the presence of feedback loops in this example points to the validity of the systems model of policy process as outlined in Chapter Five (Easton, 1965).

In the above examples the Government appears to play a benign role of supporting new developments. While playing a decisive role in legislating for change or helping to disseminate key documents, it allows these bodies to take initiative. Of course it is implicit in its action that if the direction of change is not acceptable, such support may not be forthcoming.

This (report from advisory body on postgraduate education) won't be politically contentious, so it will be released very quickly I would think. It's things that have cost implications or negotiation implications for the department that get sat on.
(GP educator 2)

This contributor calls into question the reality of this advisory group's independence. In other words it is not worth its while to be involved in projects that would not find favour with the centre.

Instability of power

What is the evidence for my statement that, globally, the hegemonic model is more accurate? The pluralist perspective proposes that, for reasons of influence, there is a fragmentation of power and competition between the stakeholders. The hegemonic view admits that there is an instability in power distribution and that different groups can gain ascendancy. This would be the case if we could show that other groups emerging in the analysis (professionals or educators) have been or are capable of holding the balance of power. Indeed it can be argued that until general management was introduced into the health service in the late 1980s, the professions held sway (Owens & Petch, 1995; Watkins, Drury & Bray, 1996).

The analysis appears to support the argument that the struggle for power continues. On one hand the centre, as we have seen in the previous chapter, is involved in an anti-professional drive. A similar comment comes from one of the interviewees.

NHSE wants to see an equalisation between all the staff groups within the health service. It wants to see effectively everyone dealt with on the same basis, totally at local level, without any necessary recognition. But there are different needs – there are uniprofessional issues as well as multiprofessional ones.
(GP educator 2)

The centre is seen to be promoting the levelling process, to be removing differences that favour one professional group, namely medics, over the others. But is the ascendancy of the managerial class easy? Not in the perception of another observer:

The problem of the Secretary of State, especially in dealing with health professions, is that there are so many bandwagons being pushed - so much high politics within medicine. So it's very difficult to know whose opinions to take if you haven't got some sort of more independent sounding board. And I soon became very aware of where the politics were being thrown on to the table by some of the professional organisations (in the meetings of the advisory group).
(Lay person)

The professions are perceived to have a considerable power, at least in the sense that they act as pressure groups. Is it possible to reconcile such contradictions? We have seen already that the state can operate successfully through intermediary groups, by setting out parameters for desired change and relying on an emerging consensus between the stakeholders to achieve its goals.

It is worthwhile noting that my interpretation of the evidence represents just one end of the spectrum of possible explanations. For example, Harrison and Pollitt (1994) suggested in their

analysis of the relationship between the professions, management and state, that in fact corporatism¹⁸ is alive and well. In their view, the medical profession has not succumbed to the full control of the managers - only the non-medical occupational groups have done so. It seems that the main point of resistance of the medical profession occurs at the implementation phase of the policies. In their comment about the status of the corporatist theory, they admit, however, that (p74):

.. corporatism could merely be a specific tactic employed by the state to keep powerful groups under control.

If we accept this interpretation, the hegemonic model in which the management is the key powerbroker once again comes to the fore.

Respect in power context

What are the other factors that might influence how power is operationalised? The quality of relationship between the stakeholders is crucial, especially if a consensus needs to be reached, or if implementation of a policy depends on the good-will of the key players (McCann & Gray, 1986). Difficulties, however, seem to be prevalent. Official documents may announce harmonious intentions:

The NHS Executive and the CVCP wish to develop and enhance a long term relationship between the health sector and higher education. Both sectors are financed primarily from public funds and are therefore subject to similar issues of public accountability .
(NHS Executive, 1995e)

Two major stakeholders pronounce an agreement on their collaboration. They have identified commonalities in how they are positioned vis-a-vis the public, which would allow them to share a common cause. But the reality as perceived by the players on the ground is different:

The document (from DoH/ SMAC) appears to be re-stating a well-known view in global terms but unless the document goes much further than this it will have very little impact. It does not appear to advance the solutions.
(Trust manager 1)

¹⁸ Corporatism as a model suggests that there is a co-operation between the principal interest groups and the relevant government departments.

This manager holds the product coming out of the department in low esteem. In fact, there is a note of annoyance present, as he himself appears to be committed to achieving the document's aims, but fears it may not be useful in backing up his action.

Another manager tackles the issue of relationship between the clinicians and managers.

Barriers between managers and clinicians need to be broken down (that's your territory/this is my territory- don't step over the line) and there should be no need for conflict arising out of divided loyalties.
(Trust manager 2)

Here the wish is for better co-operation, which, according to this manager, cannot occur if defensiveness and mistrust prevail.

Even if the thesis that I am advancing is that the power balance in the welfare state has changed, opportunity for dissent and resistance to change is never far away.

8.2.2 The manager group - new power locus

Three functional positions will be discussed in this section. One is the state with its links with other stakeholders in CPD/IPE. The second and third deals with health authorities (and other employers) vis-a-vis policy implementation, and how this group of managers relates to other stakeholders.

Actions and intentions of the state - relationships with other stakeholders

The analysis starts at this point since in this discussion the state emerges as a crucial point of reference. I will show how the role of the DoH and NHS Executive has expanded as they have exerted increasing influence on the shape of professional education (Salter, 1998). Their perception of the function of education appears to have changed, in tandem with their conceptualisation and construct of the professional learner. Why has this happened?

Using the systems model of policy-making (Easton, 1965), the answer lies in the new pressures or demands that have created this policy move. Most of the forces were identified in Chapter Four: the economic and demographic changes demand an alteration in the function of the welfare state, and the role of professionals within it has to follow suit. Changes in the ideology of the ruling party contribute to this explosive mixture.

The NHS reforms separated the functions of purchasing from providing health care. The purchaser-provider distinction has now been extended to education for some health care professions. Under existing arrangements health authorities increasingly contract with institutions of higher education to provide programmes of education and training for nurses, midwives and the professions allied to medicine.

(NHS Executive, 1995e)

Commitment to a market philosophy has become one of the defining features in the organisation of the NHS (Klein, 2001). It is consistent with this philosophy that the same pattern of relationships, which converts collegial collaboration to a monetary one, would wield its influence within the domain of professional education.

The question then is: how does central government implement its intentions?

The state and its instruments of power

The main tools of power and influence held by central government are legislation and financial resources, supplemented by the quality assurance process and an increased level of accountability in the system (Farnham & Horton, 1999).

As already outlined in Chapter Four, the Government began to promote CPD and IPE in recent years through legislation rather than through tacit support as had been the case hitherto. Of course, the process is frequently more subtle than this, as seen above - other bodies might appear to take an initiative, that then becomes formalised through legislation. On the other hand, the guidance from the centre wishing its legislation to be implemented can be very directive.

Areas of particular priority for training provision are identified in Annex 2. These relate to the implementation of Government policy and specific areas that appear to receive insufficient attention in authorities' training plans.

(Department of Health, 1997b)

Local authorities are left in no doubt that they are failing in their task, which is then made much more explicit. Compliance is expected. It is likely that one of the levers is monetary, as financial allocation for training (of social work staff, the subject of this circular) is made centrally.

In the case of CPD, a much tighter control of expenditure is exercised by the government and the employers. The features of the managed market are reflected in the hegemonic model, in that control is retained by those holding the purse strings.

The other role for the planned educational development is based on national intentions which are currently being worked out. The intention is that there will be a levy at the national level and from the regional budgets and money will be available for the regions according to a particular need, a particular need that will need to be made quite clear to the centre.

(Medical education manager 1)

As will be noted later, being in charge of the finances does not automatically ensures their good use. Notwithstanding this comment, the power interplay between stakeholders can emerge in terms of the allocation and prioritisation of resources or in specifying educational priorities. It is linked to their desire for continued existence and growth of influence (McCann & Gray, 1986).

Increased control is further supported by the mechanism of accountability in the shape of quality assurance (QA). Two aspects of this device will be explored. The first concerns the origin and the second the operationalisation of QA.

There is the increasing demand for greater explicitness about the quality of the product to be delivered - both education and service - and this is being decided externally to the organisation.

(SCOPME meeting minutes)

What does 'externally' mean here? The demand is not from the public alone, but is primarily from the government. In Coote's (1993) terms, this fits in with the managerial definition of quality. The corollary is the removal of power from the professionals, whilst still not increasing patient involvement, as argued for by Donabedian (1992).

The next question relates to who is involved in QA.

From EL (95) 86 discussion picked up among others the key role of consortia in monitoring quality education provision, in the first place an appointed monitoring officer. Note comment from Ms B that not all education providers are delivering high quality.

(Field notes - Health authority education advisory group meetings)

In this situation the instituted format of quality control is external, not internal to the educational organisation. This is rather surprising, as in the higher education sector a combination of both systems operates - and external scrutiny by QAA (Quality Assurance Agency) is aided by internal systems being put in place as well (Brennan & Shah, 2000). Of course it is possible that the internal quality control was thought to have been inadequate, as commented on by Ms B. This is also consonant with the managed market stage of relationship between state and educational institutions, as noted by Tapper and Salter (1995).

Can a change in the accountability profile be seen elsewhere in the system? While it may be argued in the case of the medical profession that most of the detailed control is in the hands of the professional education hierarchy, it is significant that directors of postgraduate education are now legally employees of the NHS Executive. That is, they have become civil servants, with all the implications of accountability and corporate responsibility (Salter, 1998). Minutes of a meeting clarify this position.

The new position would be known as Dean of Postgraduate Medical Practice; both CRAGPIE and the Director of Education had agreed on this title. The new regional deans contract would in part be with the civil service and in part with the University of London.
(GP tutors meeting minutes)

The deans' independence is being tested. They have associated workforce planning with the profile of professional education as articulated by the manager group. As I have noted in my analysis, they now belong to the intermediate group. I shall return to this later.

The pluralist model does not fully accommodate the overwhelming influence of the employers who demand a workforce capable of fulfilling their efficiency targets, and who therefore exert pressure on the government to legislate for changes in the organisation of professional education. While the professions still have a considerable influence on the policy-making process, the state is driving the agenda by trying to influence standard-setting and its monitoring by the professional organisations (Watkins, 1999).

The model that fits this picture much better is the hegemonic one, in which the interests of the management class are closely aligned to those of the state.

Actions and intentions of the health authorities and employers - policy implementation

Besides developing local policies, these bodies are involved in adopting central health and education policies, in other words in policy implementation.

Relationship to the state

How can the relationships at this level be conceptualised? As mentioned before, I have proposed that these stakeholders are in the hegemonic position vis-a-vis other groups such as professions, in that they work closely together with the state to implement its policies. They are also in a position to influence these policies by communicating their priorities up the chain of command - see for example quote on the previous page (Medical education manager 1). ('Command' is not

intended to imply that the structure is totally bureaucratic, though clearly there is some degree of bureaucratic control present - see the quote from (Department of Health, 1997b) on page 218. Much of the control is through the accountability framework and shared agenda.)

The relationship to the centre is not always that straightforward, as documented in my notes from a meeting.

Dr A believes NHSE did not particularly understand a couple of submissions (quality of information or understanding or rather lack of understanding of frame of reference on either side appears to differ). Not approved primary care team development post which was in any case intended to save money from central budget.

(Field notes - Health authority education advisory group meetings)

Tensions can arise with ease, as the intentions or detailed knowledge of the HAs may not be fully appreciated by the centre. The problem may well lie in an inadequate process of communication. In any contact, between individuals or organisations, this needs to be clear and unambiguous, otherwise misunderstanding and conflict can arise.

Factors in policy implementation

Three factors modifying how policy is implemented came up in the analysis: the process of negotiation and actions of change agents, the role of resources, and - reflecting the observation above on communication - an intent to develop a common language. A degree of collaboration between the stakeholders is required during these processes (McCann & Gray, 1986).

From a conceptual point of view, in addition to the hegemonic power axis, there is a pluralism at work: a degree of competition between the HAs themselves for the resources available from the centre. Each HA is trying to make a good case for receiving more resources, especially as a number of them have incurred substantial debts in recent years (Levitt, Wall, & Appleby, 1999). A similar observation applies to the relationship between the trusts and the health authorities. While the trusts negotiate contracts with the health authorities, they need to be keenly aware of the competition from other providers, whose profile might fit in better with the HAs plans.

The agency (HA) sees a need for change and rolls out the need to change to the providers and says what can we do about this, help us. And the providers will come in and say well we don't think you should cut this unit. However, we don't have any choice, and economies of scale demand that cut. You can't have a neurosurgical unit because you haven't got an MRI scanner and that's

fundamental in technology nowadays. We might have worked like that 20 years ago but you can't now.

(Nurse education advisor 1)

Power in such negotiations appears to be unequal and is linked to the health authority holding both the resources and a firm view on organisational standards. The internal market has indeed begun to make an impact on the provision and shape of service organisation.

In addition, pluralism is evident in how the policy is implemented. Different interest groups at local level impact on this process, and while there is a degree of interdependence between the actors, competition for resources and for influence on decision-making is rife. The balance of power has been changing recently, as this respondent commented.

We have a huge amount more power than we have ever had. Traditionally I think colleges of nursing's main business was pre-registration education, whereas now most of the money impacts in post-registration. And they have to see us differently because, if we don't buy it, they have to cut their staff. And it has become that brutal, whereas the two organisations were very separate before.

(Nurse education advisor 2)

In the 'good old days' before the introduction of managerialism into health service, there was a greater equality of power. Hospitals did not have direct control of educational budgets and they had to channel their requests through the region. Since financial control was devolved down to trusts, nursing colleges' ability to influence the shape of the contract has diminished (Smith, 1997).

These processes need to be managed, for as Ham (1992) suggested, policy-making or the implementing process at this level can be stalled by the equality of power between the competing groups. Yet from the cases illustrated above, there seems no danger of that happening. Quite the contrary, it could be argued that the introduction of New Public Management (Farnham & Horton, 1999) is predicated on removing that equality of power to improve decision making.

In the second half of this chapter I will focus on languages or discourses used by different stakeholders to achieve their aims. Here I will pay attention to a more transparent and explicit aspect of language use, which links very closely with comments made earlier about the need for effective communication.. One perception was held as key by many stakeholders within the manager group - a wish for shared understanding. This comes across in this circular:

The creation of patient-centred services is likely to demand flexibility and involve employers defining new roles. It is important that new responsibilities and performance requirements are expressed in the common language used for

occupational standards. Using a common language will - in the long term - support more effective dialogue between commissioners and providers. Occupational standards defining expected staff output can make a useful contribution to establishing quality in the contracting process.
(NHS Executive, 1995f)

A common language that would allow the relevant stakeholders to define the parameters of their interaction is held quite pivotal to this process. There is some dissonance here. Sharing a common language implies a greater degree of collegial relationship than has been demonstrated so far. Or is it possible that a common language is thought of here more as something imposed than developed in dialogue?

Actions and intentions of the health authorities and the employers - relationships with the other stakeholders in professional education

Here I concentrate on those relationships that exclude links to the state, since these were elaborated above. These links, however, need to be kept in mind as they set the wider agenda within which the health authorities and the employers act out their roles.

What are the features of relationships between these stakeholders? Two broad themes have been identified - the issues of power and changing stakeholder roles.

Power and its manifestations

The key characteristic here is the degree to which power is exercised directly - how much competition or collaboration takes place. The changes in power and establishment of new bodies where it is located have an inevitable impact on the autonomy of professionals and education providers.

Power may indeed now be located more in the management class, but the professionals or educators may not find this change easy, as was noted by this GP educationalist.

The history of the last five years has been one of the GP tutor structure coming to terms with the number of new relationships that it has to make. Now to start with it was the FHSAs, in this region and their funding of education meant that they wanted to have some control over it naturally and so there was a need to develop relationships with them, which is going on at the moment, but there wasn't at that time a need to develop relationships with undergraduate departments who were not involved with CME.
(GP educator 1)

In the background one can see that different sets of priorities clash and different perspectives may create a climate of suspicion. Managers want education to be more responsive to service needs. As outlined earlier they also want it to be a part of workforce planning within the context of the shift of care from secondary to primary health care settings, and to be congruent with the skill-mix exercise (Jenkins-Clarke et al, 1997). In the other corner are GP tutors, who relate to GPs as their constituency and wish to address their learning needs.

Once some degree of working agreement has been reached, co-operation is necessary to help to implement the changes.

I am working with our main education providers to look at what they're providing and the quality and the standards that they set within that and they've included me in their course planning team for across both universities.
(Nurse education advisor 1)

As power is more diffused in the system, a more collegial relationship is required. At this level, where bureaucratic control is more difficult to implement, consultation and negotiation takes precedence over direct control. Contracting, as described for example in the quote from NHS Executive (1995e) on page 218 on separation of purchasing from providing, is by its nature a collaborative process, even if inevitably it occurs within the context of inequality of power - for as we have seen, it is the funder who has the upper hand.

The picture obtained during data-gathering represents a transitional phase. This ought not to be surprising as the field of health care and associated professional education is changing all the time. The most important transitional feature of the change is the location of the provision and the commissioning of professional education for non-medical staff. In the next section I reflect on the role of the educational consortia, but suffice to say that during data collection these were in the embryonic phase. Their role was anticipated by this interviewee.

The (health care) provider is actually the purchaser of education and because of the new consortia arrangements under Working Paper 10 that money is devolved down to a consortia of providers who look at what they want for their manpower to provide the service that they need. The commissioners (i.e. HAs) are sort of five years down the line saying, 'Look guys, we're going to reshape this service and we think you're going to need training here, here and here to accommodate it.' That's one way the commissioners can influence it - for future planning.
(Nurse education advisor 1)

It is interesting to note that this contrasts with her more co-operative previous comment. Here she makes a much stronger point, suggesting that there is a degree of coercion present. The health

authority itself is moulding the educational provision, but doing so indirectly, by putting pressure on trusts.

At the same time, in anticipating the change, the authorities had to develop structures with appropriate educational functions. This can be seen in health authorities and trusts employing educationalists, or establishing advisory groups whose remit is to assess educational needs, co-ordinate such findings, and (in the case of trusts) commission education. I summarised the remit of one such committee as it was beginning to develop its role.

The role of the advisory committee is to feed information to chief exec, to provide opinions to new educational consortium, and to develop an overarching strategy.
(Field notes - Health authority education advisory group meetings)

Of course, the trusts have been involved in this field all along, but in many cases they lacked a co-ordinated approach and these roles were diffused among the different managers (Rogers & Lawrence, 1987).

The second, related, change is a conceptual shift within these organisations from CPE to CPD, from a professionally-defined remit of education to management-designated and organisation-centred goals. A directive from the centre spells it out in detail:

Education commissioners should promote the provision of programmes and opportunities which strengthen links between personal and career development and management; organisational development, management and leadership; and the enhancement of clinical effectiveness and the updating of clinical competence.
(NHS Executive, 1995a)

The educational stall is set out very clearly - organisational needs take precedence.

All of the above issues have a considerable impact on professional autonomy. Professionals are coming under increasingly closer scrutiny, not only in the performance of their professional tasks, but also in their choice of educational fare. The move to CPD entails changing priorities for learning - the autonomy of choice is curtailed. This can be presented as a *fait accompli*.

The professionals will advise the educational consortia having identified what their learning needs are at various levels of the professional management but it should be the trusts, i.e. current purchasers, who will contribute membership towards consortia. The professionals will be expected to log nuts and bolts of learning assessments and contribute to planning of education but managers must

take a much greater role in making decisions on the basis of that information and whatever plans they have for the service development.
(Medical education manager 1)

The professionals here are reduced to some mechanical tasks (of needs assessment) and to an advisory role (about their own learning needs). This, not to put a fine point on it, seems to infantilise them. I will come back to the issue of professional autonomy later on.

Changing roles of the health authorities and trusts

Two further roles in professional education can be discerned for the employers. One concerns the demand on employers to ensure appropriate educational standards for their employees, and with it the support required to achieve these.

While most of these comments relate to trusts, a number are relevant to GPs as employers of professional staff, mainly of practice nurses. The trusts have recently come under an additional pressure as they now face demands from professional organisations requiring particular educational standards from their members (e.g. UKCC (1997)). A pluralist scenario comes to the fore as the power relations are complex.

Marrying the interests of a Trust Board with nationally imposed CPD requirements may not be easy. There are funding issues to be resolved.
(Professional body officer 3)

Thus a question arises: whose responsibility is it to achieve these standards in the case of a professional worker? Is it the employer's or the professional's? Whilst the latter may see a need to be accountable to his or her professional organisation, the fact that the employer has control over the education budget implies control over the content of education.

Problems arise if education and service priorities do not coincide and staff do not get release for courses. As one respondent noted, such discrepancies may have a deleterious effect on the future of the trusts' survival.

But the organisations that will succeed where others fail will be those that invest in the people they have. And it will be those organisations that, for example, take serious account of the UKCC's new requirements for preparation for post-registration practice, PREP recommendations, and recognise that we are, and should be, heading towards an all graduate profession for nursing, and that it means in fact enabling large numbers of nurses to enter to train for degree courses from now on.
(Nurse education advisor 2)

This might appear to be a dispassionate assessment. However, it is likely that the speaker sees a major advantage in the nursing profession growing in status - and raising educational standards is a necessary step towards this (Moloney, 1992). From this viewpoint the power is still located within the professions. The pluralist concept of power holds the explanatory focus for these apparently contradictory perspectives.

In summary, what we see is a gradual shift of control over continuing professional education from the professionals and the educators to the managers. This is shown in the changing structural and functional frameworks and is consonant with the proposition advanced already. That is, the hegemonic axis moves away from the professions and the education system to the manager group. What is the impact of this move? As management's primary need is to have an efficient service, the potential danger lies in an education focussing on short-term outcomes. A long-term perspective is frequently lacking in these considerations.

Notwithstanding the ascendancy of the managerial class, the picture is more complex in the messy world of policy implementation. The power balance is unstable and allegiances shift continuously.

8.2.3 The intermediate group

I propose to discuss the intermediate group (see Table 8.1) under the manager heading, since, as already suggested, its orientation appears to be closer to the manager group, structurally and functionally. It has emerged, as I will show, to mediate between the three key groups - the managers, professionals and educational system. Whilst some of its parts have been in existence in some form for some time, their remit, structure and responsibilities have been developing constantly, and increasingly so in recent times.

Two questions will be answered in turn - why did this group assume greater power and how did it do so? In addition, I will illustrate the changes that have taken place to accompany this power shift.

Shift of power - motives

While this is a heterogenous group, the focus of power that it has assumed in recent years supports the trends identified above. The driving force coming from the manager group is a need for a closer integration of education with service needs. This then determines the education agenda. The education managers, who usually come from a professional background, assume a new role, where

their accountability is more towards their employing organisation rather than their profession (Walters & Clark, 1993). Their awareness of the changing context within which they have to operate is reflected in the following comment.

Practice nurses' education was the responsibility of several people and it hadn't actually been thought about in that way before. It had always been thought of as the practice nurses' and the professions' responsibility and in actual fact the commission has had responsibility for the quality of the product at the end of the day.

(Nurse education advisor 1)

A more strategic view of the education system, its role and how it functions now has to be taken and the intermediate group is well placed to assume that task. This responsibility in effect gives this group increased power.

Not all interventions from the position of power need be seen, however, as manipulative. A more positive view can emerge when a need to alter the direction of CPD is accompanied by a sensitivity to the reality of professional and personal situations.

I have to have that vision that despite the fact that if you go into this district 70% of the GPs are overseas graduates coming up for retirement who are antagonistic to anything new, I don't think one can give in, but one has to find common moral values with that group which can represent a strand through which education can start to be delivered in a different way.

(GP educator 1)

The speaker approaches a difficult situation with an assumption, based on respect, that an appeal to professional motives could alter negative attitudes. He also carries a strong conviction that change in CPD is essential. As a change agent (King, 1990), he appears to be taking a right course of action.

Tools of control

How are the changes accomplished? What are the tools of control? Four such tools have emerged in the analysis: resources, use of documents, negotiation and accountability. These have already surfaced in the manager group. This ought not to be surprising, since these two groups are connected and the intermediate group carries out some of the tasks of the manager group vis-a-vis professional education. As the intermediate group is closer to the professionals and educators, its use of these tools needs to be seen even more in the light of the pluralist perspective on power, which is built on a more interactive type of contact.

Having control of the money for education certainly gives the funders considerable scope to change the shape of education provision. Education providers are learning to become more responsive, as commented on by a number of contributors:

But certainly providers have shifted, in some areas quite considerably as a response, because they are driven by money, because of the market principles, this has been very effective in some areas.
(Medical education advisor)

This is one of the key messages coming out from this study. Even if it accepts being in the market reluctantly (Becher, 1996), the education system is forced to adapt in order to survive. In some cases the allocation of funds may favour one group over another. Whilst mainstream funding has kept the medical education streams separate from non-medical (Department of Health, 1990b), a new initiative such as LIZEI can throw these differences into sharp focus.

Payment could only be for GPs attending and other practice staff would need to obtain funding elsewhere. A certain amount of funding for support was recognised and there was special money available to the end of this financial year for successful bids by the Health Agency on behalf of other health care workers. There was concern that there may not be enough money to go round .
(Education Board minutes)

LIZEI was designed for GP educational development in London. However, as the committee members noted in this discussion, this policy was short-sighted, as it ignored the obvious need to develop other members of the primary care team. They appear to be second in line for a financial handout. This situation clearly signifies the lack of a strategic approach. It might also reflect inadequate expertise on the part of the policy makers in assessing learning needs within a wider context of service development in needy areas such as Inner London.

Another tool of control, familiar in any organisational development, is the production of documents. While in many cases they appear to be directive, one of their important functions is to create a shared set of meanings that contributes to fostering a common culture. Once such a culture is established it becomes easier for the key stakeholders to communicate with each other and to achieve change (Nyström, 1990). The proposition linking these factors is outlined in one such communication.

The LIZEI programme has the slogan "Development Through Education", a phrase which appears on its logo and other publicity material. It summarises one aim of the programme, which is to develop primary care within the London

Initiative Zone to enable it to take on roles already routine in other parts of Britain, and also to rise to the challenges of "the primary-care led NHS".
(Education Board minutes)

The above quote goes one stage further. It re-iterates another common symbol of organisational culture - its mission as expressed in the slogan. This particular expression appears on the surface uncontroversial and it can be safely assumed that it is acceptable to all the stakeholders. What is not clear who has formulated this slogan. Was it created through a dialogue between all concerned, or, more likely, imposed from above?

Negotiation is a familiar aspect of communication between parties with roughly the same degree of power. The purpose of such a contact is to work together in implementing central policies. The education system may feel under pressure to initiate such a dialogue, as I noted:

An example where change requires co-operation is the introduction of the Calman Report where direct costs required to train the consultants to train/teach have not been calculated for, therefore the original education system has to develop partnerships with trusts and health authorities so they can help to finance that element of Calman's implementation.
(Field notes - SCOPME meetings)

Negotiations in such a scenario would need to be conducted with sensitivity as the power balance is uneven, and the purchasers, in fact, need to be convinced that expenditure on training is required.

Accountability has surfaced in many guises in this work. As noted before, it is a necessary part of the system, whereby a degree of freedom is devolved to the periphery. In the cases of the intermediate group, in most instances it seems to refer to accountability for the appropriate use of financial allocations.

A budget statement prepared by the steering group is attached; it will form the basis of funding transfers from the Centre. I should be grateful if you would let me have a note of the financial mechanisms your education board will adopt in managing the local budget.
(Education Board minutes)

It could be argued that this level of supervision makes good managerial sense. Why should not responsible financial arrangements be formalised?

We have seen above how power is actualised by the actors in this group. As they are in essence a part of the chain of influence (rather than command), they need to use a somewhat 'softer' means

of achieving change. While higher up in the hierarchy legislation is one of the key instruments of power, here negotiation becomes more important.

Changes in structure and function within the intermediate group

The changes in structure in this group have been numerous and have been accompanied by functional realignments.

I have already noted three such structural changes that mould the activity of this group of stakeholders, namely the role of Health Regions, changes in postgraduate medical structure and the appearance of educational consortia. I will also look at other changes, such as the role of education managers and GP tutors.

First, the role of the Health Region has changed. In the case of non-medical education, most of its functions are devolved to educational consortia (see below), while it retains the monitoring brief.

The Regional Education Development Group (REDG) will be an advisory and development group - but longer term it will monitor and approve consortium plans. The region will have overall responsibility but will delegate as much as possible to the consortium as they mature.

(Health authority education advisory group minutes)

This development is in line with other changes observed in the health service and wider field of the welfare state. More of the actual work and decision-making is devolved from the centre, which mainly retains a planning and strategic function. The Centre-Periphery model of management of change (Schön, 1971) fits this pattern.

Secondly, the postgraduate medical education structure, at least in the case of the directors or deans of postgraduate education, is now aligned much more closely with the civil service.

Third is the advent of the educational consortia. At the moment they hold funds for non-medical education, and the majority representation on them is from the management group. However, since their inception in 1996, they have had on their agenda co-operation with the medical education structures. In the future it is possible that they will assume a more direct control over this part of professional education as well. One of the unresolved tensions underlying this move is the greater relative independence of the medical CPE structure and funding (Calpin Davies, 1996). The story developing in the quote below continues the one started in the previous quote:

The local groups which will be planning or commissioning the education have a need to show that they have the required competencies to the regional group. To start with it will concern mainly nurse training. The organisation of educational consortia will need to take into account planned work force requirements.
(Medical education manager 1)

Education consortia are set to take on the devolved role of linking education to service requirements. A logical part of it must be a wish to create a much better overview of workforce planning that would cover all the occupational groups. It can be seen that transfer of responsibility is gradual. There is a need to ensure that the system works well, that it is able to deliver according to the plan.

In the same category, or at the same level of the educational structure, it is worthwhile coming back to the (GP) educational boards and their function. Educational boards have the aim of uniting the different strands of GP education i.e. undergraduate, postgraduate and CME. In most cases they are not multiprofessional. Their role and power is dependent on how much the individual strands are willing to cooperate and on the funds of which they dispose. Within Inner London their remit covered control of LIZEI funds (until April 1998, when this source of funds ceased), while elsewhere they need to rely on the slow process of changing the perceptions of key players. Its officers see a central role of this organisation being shaping the education of the primary care professionals within the context of the changing reality of primary care. This is seen in the quote below:

The strategy of the Educational Board will focus on:

- allowing for and responding to the increasing emphasis on primary care and the role of the primary health care team,
- representing, promoting and facilitating the personal and professional development of GPs reflecting individual and practice based needs,
- ensuring that the strategy is comprehensive, sensitive and responsive in its approach to allow for continually changing needs of service provision,
- linking with educational consortia to ensure effective representation.

(Education Board minutes)

They also see, as noted here, that they cannot operate in a vacuum. Close co-ordination with other stakeholders is required. The appeal of this strategy builds on an awareness that to promote change it needs to be congruent with philosophies (Becher & Kogan, 1992) prevalent in these groups - GP independence and the need for change towards managed service in the manager group.

The function of the education manager or purchaser in a trust (or health authority) is changing due to the establishment of educational consortia, as now they need to work through them. Until now such a person had a dual role. First, to work with the purchasers (or providers) of care on standards

of education or competence to be incorporated into educational (or care) contracts within the context of strategic plan of service development. Second, to work with the education providers to customise their educational offers to suit these plans. This has been seen in the quote on page 224 (Nurse education advisor 1). Their role has not always been easy: difficulties in coping with organisational changes or the wish to work in a collaborative fashion militate against disturbing a 'steady state' too quickly.

There has not been much change in the way we purchase education. Partly because it's early days; partly because there isn't total freedom to send nurses wherever you want them to go. Partly because all of the education institutions are struggling with their new arrangements, whether they're going into higher education, whether it's the merger of colleges of nursing creating organisational upheaval. But also, we don't have huge amounts of time to develop curricula, validate courses and purchase courses from many institutions. Particularly as much of our training is locally focussed and customer specific, then we don't really want to be counting short study days and short courses all over London. We want somewhere locally and accessible.

(Nurse education advisor 2)

The realisation of obstacles in the way of changing established patterns of work is refreshing. It is characteristic of a collegiate relationship that has existed for some time that change has to take place in a measured way (Walters & Clark, 1993). Nevertheless, the inequality of power is evident.

The last aspect of changes in educational structures refers to the altered profile of GP tutors. Whilst until recently they were semi-autonomous, now they are becoming part of GP postgraduate education structure and their responsibilities are changing accordingly. As I noted, they still

have a somewhat undefined role, undefined job description and need to develop their role and specify the remit of their function and also what links with other stakeholders in CPD they need to develop.

(Field notes - GP tutors meetings)

However, they are now required to take an active part in an overall plan for GP CPD. It is not enough just to respond to the demand of GPs and provide only popular educational offers. Other, external, imperatives begin to impinge on their work (Singleton, Smith, & Hornung, 2000).

Whilst power inequalities are evident, the implementation of all these changes by the actions of the intermediate group members is still subject to the pluralist scenario. Negotiation and consultation are essential tools in the system, yet the agenda is dictated from above.

8.2.4 The professional group - the professions under siege

In this group are included professional organisations and the professionals as individuals. Some professional organisations, such as the BMA and RCN, have the functions of representation, others, such as the medical Royal Colleges, UKCC and ENB, maintain academic standards. Whilst each has a separate role and function, concern here is with the common features. The relationship of the professional group to the state and the employers was explored above. Here I turn to the role of the professions vis-a-vis CPD and IPE.

What are the challenges the professionals face and what role do the professional organisations play in the current system?

Context of professional action - changing perceptions of professionals

The changing national context within which the professions operate has been extensively explored. I will now analyse in some detail how perception of the role and function of professionals is changing. The underlying discourses will be looked at later (see second half of this chapter), but now I want to look at what possible implications this might have on professional education. This analysis will provide a basis for understanding of role the professional organisations have had to adopt recently.

One of the characteristic features accompanying the altered perception of the professionals is the movement towards de-professionalisation. This has been seen with the promotion of the uptake of NVQs by unqualified staff (see also Chapter Seven) and shifting boundaries between the professions.

So in that sense upskilling nurses and other professionals made them more autonomous; they're able to use the judgement based on the theoretical and practical training that they've had and therefore provide a better service - not only for the patient but for the colleagues that they're working with. Because as we know, in the past we had to wait for the doctor to do everything.
(Nurse educator 1)

The traditional role and status of the medical profession is changing. Other professions are undergoing the professionalisation process (Moloney, 1992; Turner, 1995), and their dependence on medical decision making is consequently diminishing. A more complex picture emerges when the remit of professional action is analysed in more detail. As already discussed, the introduction of skill-mix (see Chapter Seven) has had an impact on all involved. The only way the modern

health service can cope with demands for ever increasing range of procedures, beside employing more staff, is to upgrade the existing staff at all levels. A defensive reaction, then can be understood:

Medical trainees in public health have become rather protectionist about their career opportunities not wanting them taken over by cheaper non-medical staff.
(SCOPME meeting minutes)

Is this a reactionary response? Are these people not aware of the need to work in a more rational way? Obviously to them professional self-preservation is more important.

Threat to professional autonomy

The second feature underpinning the altered reality for the professions is the power shift away from them to the managers. This hegemonic shift results in the changing perception of the professionals in terms of their designation, and also begins to limit their freedom by tackling the hallowed aspect of professionalism - autonomy of action and decision making (Abbott & Wallace, 1998). At the level of professions this can be seen in the way the professional bodies will be changing, as suggested in this review of the Nurses, Midwives and Health Visitors Act:

The purpose of the statutory body is to protect the public through setting and monitoring standards of professional practice, education, and conduct for nurses and midwives; and to influence the development of these professions in the public interest. The accountability of the Council in all these matters is to the public first, and secondly to the professions that establish and fund it.
(J M Consulting Ltd, 1998)

The focus of responsibility is to the public. However, it is the state, that takes on the role of voicing and acting on the need to change professional self-regulation. The move to the managerial phase of professional regulation is happening (Siegrist, 1994). At the level of the trusts a similar process is taking place:

The main reason behind re-organisation is that there is a duplication in infrastructure arrangements that make service inefficient. What is yet unspoken is how the power or the autonomy of clinical groupings (such as the PAMs or Dentists) will alter. The resulting loss of autonomy and loss of power would be dependent on how other parts of the organisation step into the breach.
(Human resources person)

The drive for efficiency is removing the cobwebs of long-standing and cherished arrangements. The managers in the quote above are aware of the impact of the proposed changes, and for them professional autonomy is of little value. The pressure for change is apparent in a number of areas: organisation of work, support systems, the need to work more collaboratively with other

professional or occupational groups, and pressure to alter the learning approaches. Resistance is present in the system, as predicted by innovation theory (Damanpour, 1990), through slow adoption of new ideas, or non-participation in events designed to usher in the changes, as is seen in the case of IPE below.

Doctors may resist inter-professional education (e.g. by not appearing at meetings where this is being discussed) for a number of reasons including: time pressures, perceived threat to their status as leader, perceived threat to clinical freedom, fear of appearing ignorant, concern about legal/professional responsibility or lack of interest/perceived relevance.
(Professional body officer 2)

While the issues enumerated here fit in neatly into the category of individual inhibiting factors to the introduction of IPE as proposed in Chapter Four, here this type of resistance can be seen in a different light. Interprofessional education with its promise of opening up and questioning the established order might be, however unconsciously, considered to be a management rather than professional priority.

Challenging professionals' freedom in education

Why is freedom of professional action not acceptable? What are the underlying issues that are determining management action? Three interacting issues were identified in analysis and in line with the enquiry they relate to professional freedom of choice of learning methods and content: professionals in this view need to be accountable as they are seen to assess their learning need inadequately and choose their learning inappropriately. In consequence the managers have to take a more proactive role in professional education. This discussion echoes the exploration of CPD and work-based learning findings presented in the previous chapter.

Accountability is one of the features of the new management approach to running the welfare state (Gaster, 1995). In the case of professionals, it means being accountable, through monitoring systems, for their action and also for the use of resources, both in the care process and in education.

FHSAs are becoming much more involved in GP postgraduate education, and in that of the other professional groups. It is about accountability. Persuading all the professions that they are accountable for the use of public money and, being the people statutory responsible this expenditure, the health authorities, it's in their interest to educate the people working for them, about that accountability.
(Health authority manager)

This respondent voices a clear wish for the professions to realise that they are a part of the system and have to take a responsible attitude to fulfilling their role within it.

There is a potential pitfall inherent in the obsession with accountability. Filing reports, besides eating into professional time, creates an atmosphere of suspicion and mistrust and questions the key professional values.

The problem with the way the NHS and professions within are moving (towards evaluating learning) is that people know the cost of everything and the value of nothing.

(GP educator 2)

Comments like this reject educational evaluation in its totality. It implies that evaluation is only concerned with output, and in financial or efficiency terms at that. Of course, evaluation that is concerned with the development of learning provision ought not to neglect the funders' interest, but the main thrust should be with changing the learning experience to help learners to fulfil their needs (Rossi & Freeman, 1993).

The professional as a learner, according to my analysis, is seen by the managers as having freedom of choice without necessarily taking into account the constraints of organisational needs and the education market place. This freedom can be perceived as inappropriate. Such a view represents the normative definition of learning needs (Graham & Mihal, 1986). While there may be support for the principles of adult learning (more of this later), the professionals need to behave responsibly in assessing their learning needs.

Educational development should start where people are. There is much that is excellent about the current educational provision. This should be consolidated and expanded. Having said this, some people are not aware of their strengths and may need some help to do so. They should identify elements of good practice, appropriateness and fitness for purpose in what they are currently doing. Through this reflection they should also identify issues and problems within their current professional provision.

(Health authority education advisory group minutes)

Such a balanced and supportive view was not shared by many respondents. Disregard for the organisation and for other team members was one of the reasons a more accountable system was advocated.

We have to prioritise the service angle, as opposed to personal development. And it has in the past sometimes been unfair in that most profiles of nursing work forces were showing that the most qualified, most highly educated nurses and

most senior in terms of where they are in the hierarchy, have accessed disproportionate amounts of education and training.
(Nurse education advisor 2)

The move towards increased power for the managers was evident in their closer involvement with the whole educational process, as we have already seen. One aspect of this is the interest shown in learning needs assessment through devices such as annual appraisal, and through prioritising allocation of funds to individuals.

In the old days a course could be one day set up by somebody who thought they were an expert in something and the nurse would go along and come back and say 'I'm an expert in this now I've been to a lesson on it' and that was it. So its much tighter in the sense that we know what we're buying now.
(Nurse education advisor 1)

In the management view, such an unregulated approach to professional development is not adequate for a world requiring more planning based on anticipated skills and competencies.

However, the encroachment of management into the educational field can have patchy outcomes. An appraisal or learning needs assessment might not be done, or not done well. In a number of cases it could be said that insufficient care was taken by the managers to fulfil this role, as I noted at one meeting:

Someone without any background in education is given task of educational need assessment. What does it say about commitment of agency, their view of a need for expertise - is it just use of 'cheap' manpower, without putting an effort into advertising/ recruiting a specialist educationalist? Or can it genuinely be seen as a developmental role - using an intelligent person to do the job.
(Field notes - Health authority education advisory group meetings)

Perhaps it is to be expected that a perfect or even reasonably adequate system cannot be established overnight, and that time is required to embed the changes that would be in the long run acceptable to all the parties concerned.

Competing views of professions

I would like now to take a much wider view. The debate above raises an important question. What perspective on the professions should be adopted here? Is it one where professionals can be trusted to do their work well and to comply autonomously with the need to update their competencies? This certainly was a view held by medics at a CPD conference that I attended:

Diversity of educational provision suits the doctors best, they then have a freedom of choice, which they use responsibly.
(Field notes - CPD conference 1)

Underlying this observation is an idealised, altruistic view, that judges the profession's actions against a higher ethical criterion of selfless service to the general public. In an opposing view, as suggested by Habermas (Scambler, 1987), the professions can be seen as agents of the state, coercing the population into behaving in a particular health-preserving way and being more productive. Cruess and Cruess (1997) suggest that the health professions can benefit from the public's awareness that responsibility for the running and success of the health service does not wholly rest with them. An opportunity presents itself to retrieve their somewhat battered position.

Siegrist (1994) charts the role of the professions in modern society more benignly. His functionalist description puts the professions firmly in the service of society - their role being to maintain its fabric and scarce resources, transmit cultural values and provide impetus for new developments, both technological and intellectual.

Is it appropriate to take a more critical view of the professions? That view was described above, where the professions were seen to wish to defend their patch, were accused of short-termism, or were unwilling to change. Professional education could be one of the root causes:

Professional education tends to reinforce its own importance as a subject area which tends to lead to tribal behaviours when there is a need to work with others. They are acting as representatives of their departmental interests rather than as a member of a team in which there needs to be a sharing of a common objective and a commitment to it. The growth of professionalism is becoming intensive as more demands are made but this may lead to undermining of effective team work.
(Education advisor)

Resistance to change has appeared already a few times. In this case the wish to maintain autonomy is achieved at the expense of working more effectively with other professions. What can be the purpose of such a defensive posture? The critical view of professions is exemplified by Jarvis (1983) (p21) who quotes Elliott's (1972) (p11) opinion that 'a professional group controls a body of expert knowledge which is applied to specialists tasks', with the clear implication of a profession liable to corruption and the promotion of selfish goals. This view is echoed by Illich (1977) who argued that the professions had ceased being liberal and offering service, but rather were starting to dominate and manipulate the population through the application of their expert knowledge.

It is worth noting that a contrary set of views of the professions has been emerging, as exemplified by Freidson. While in his earlier seminal writings (e.g. Freidson (1983, 1988)) he was critical of the professions and their protectionist behaviour, in his later careful analysis (Freidson, 1994) of the alternatives (bureaucratic and market-driven) to the delivery of specialised services, he favours the professional way. Another opposing view comes from within medical sociology, which has been so critical of the power of the traditional medical establishment. Strong (1979) subjects medical sociology to a similar scrutiny and concludes that its stance might be explained by its need to establish its own legitimacy and professional standing.

For the purposes of my thesis I need to have recourse to the power analysis framework, as I see the professions and their associations as stakeholders in the struggle for influence over the fate of their members. This view would not deny the altruistic element of professional action, but even this needs to be seen against the primary call for self-preservation. The professions may be providing a dedicated service in the expectation of receiving respect and the power of self-determination in return.

Professional organisations - the vanguard in the power struggle

Now I can look at the role of the professional organisation in the light of the foregoing discussion. The analysis of power interactions suggests that the organisations assume more than ever before a defensive role. They feel the need to defend professional boundaries against the encroachment inherent in a number of NHS changes and in the challenge to traditional professional power by other professions or the government. As Churchman and Woodhouse (1999) note, professional bodies have a role in mediating between the government and the education system. Their actions need to take into account the changing environment within which professions operate (Watkins, Drury & Bray, 1996). The underlying intent is to continue to guard the entry to professions, and their attention to CPE (and more specifically to revalidation) can be seen in this light.

To fulfill their role well, the professional organisations need to show flexibility and willingness to change the modus operandi. This might include an openness to accepting alternative routes to membership, such as through the NVQ route (Watkins, 1999). Co-operation rather than competition between them may be required to stave off take-over by the legislators.

The RCP discussed with the RCN the implications of the movement towards skill-sharing and a short document has been agreed by the RCN's Council and will be considered by the RCP Council in September. The document recognises that this

is an important development and, providing it is managed properly, it is to the benefit of patients.
(Professional body officer 4)

While this is not unprecedented, as shown in my description of how IPE developed in its early stages (see Chapter Four), in this case decisions appear to be taken at the highest level of these organisations and thus suggest that such a collaboration might be successful. This, of course, would require that the practitioners themselves be in agreement with such a development (Becher & Kogan, 1992). The road towards co-operation may not be always easy:

There is some sort of power struggle between the DoH, advisory group and various medical colleges who feel that their territory is somewhat being invaded by this organisation. In other words, how does one delineate the boundaries of responsibility for education?
(Trust manager 1)

It would be naive, in the least, to expect this process of change to be smooth. Vested interests and ingrained habits die hard. Tribal allegiances determine how each profession or group sees the others. The innovation perspective throws light on this: all the parties need to see that the overall gain is greater than the loss of their isolated and protected status (Hultman & Hörberg, 1995).

To move in the desired direction, the professional bodies, beside having a political role in contact with other bodies and the government, need to be seen to maintain their leadership role. However, the type of leadership needs to be facilitative, not dictatorial, if they want the professions to change. A variety of possibilities were explored by this officer of the RCGP in regards of IPE:

The JCPTGP could play a role when inspecting practices for vocational training. The College (RCGP) could include inter-professional education in its curricula and a question about inter-professional working as part of its membership examination. Inter-professional working could be included in its assessment of GPs for the college Fellowship.
(Professional body officer 2)

Some degree of the tail wagging the dog is present here. The RCGP would, if these proposals were actualised, set markers GPs would need to comply with if they wished to be recognised for their academic or training ability.

Some differences in opinion in how, or if, these organisation are responding sensitively to the changing context, did emerge.

It is very clear that the professional bodies, the Royal Colleges, RCN and other professional associations are not looking at the professional development in a comprehensive way.

(Medical education manager 1)

This, of course, is a view from a specific perspective. The contributor belongs to the intermediate group, thus is impatient with others' resistance to, what he sees as, the immensely sensible idea of CPD.

What are the main tools for maintenance of professional standards? The primary approach is continuously changing the standards for entry into the profession in order to keep pace with shifting professional boundaries. Linked with that is exercising, even if under much tighter state and public scrutiny, the task of policing this entry onto professional registers.

In addition to the pre-registration year, all doctors entering the National Health Service are now required to undergo either specialty training under the aegis of the Royal Colleges through their Higher Training Committees or vocational training for general practice supervised by the Joint Committee on Postgraduate Training for General Practice before they may practise independently.

(GMC, 1993)

In this dry prose, the GMC very clearly states the process whereby members are accepted by the wider public as legitimate and appropriately trained professionals.

If a profession can be seen to conduct itself to high standards, to develop, maintain and monitor itself, then it can hope to avoid direct control by the state. Professions now need to behave in a more pluralist way, by joining other pressure groups in a fight for influence over policy-making at the centre.

The case of interprofessional education

I looked at the obstacles to the introduction to IPE in Chapter Three. While in two quotes above on page 241 (by Professional body officers 4 and 2), the official line is supportive, the reality might be somewhat different. Here I provide a view from a manager of how professional organisations approach what amounts to a controversial subject. Thus:

Each profession remains defensive about its 'unique' position, often supporting multiprofessional learning (MPL) only when it applies to others. 'Horizontal' working cuts across professional interests and this may be perceived as a threat to professional autonomy.

(Trust manager 1)

I would like to suggest that this comment might help explain why it took a considerable time for IPE to become mainstream policy within professional associations. The pluralist perspective, embedded within, also makes clear why co-operation between the professional bodies has been sporadic, and why it has been difficult to achieve common goals, such as the approval of dually-validated IPE courses. I have suggested that the professions' main concern is their survival. In part this can be achieved by defending the traditional remit of professional action which requires preserving uni-professional boundaries. It is possible, however, that collaboration between professional bodies can in time provide a common platform for the defence of professional freedom.

8.2.5 The educational system - education as a market

The part of the educational system involved in CPD and IPE has, perhaps more than other parts, the characteristics of the modern condition. It had to change due to the different demands put on it as a result of NHS developments and concurrent social changes (Stanwick, 1994).

With the changing profile of stakeholder involvement, the power issues emerge as central to understanding how the relationships are negotiated and influence within the whole system is operationalised. The systems model and pluralist view of power offer a starting point for an analysis of changes occurring within the system.

The systems view

While clearly until now policy-making for CPD and IPE has been practically non-existent in the education sector, this is beginning to change slowly. The major stimuli for change are summarised well in the following quote:

I think that the main thing was the fact that people at last realised that a pre-registration programme doesn't fit you for professional practice for the rest of your professional life, with the speed of change, the speed of technological change, the speed of the change within the organisation of care, the philosophy of care, knowledge gained in one three year programme is never going to fit you for the rest of your life and I think that it's part and parcel of the challenge to the professions too isn't it? That it isn't enough for the profession to say I've got the qualification, I don't need to do anything else, consumers are becoming more articulate, our patients and clients know much more and they rightly expect to have a practitioner looking after them who's up to date and can demonstrate that they've met some sort of continuing education requirements.
(Professional body officer 1)

The above issues have been explored already in Chapters Two and Four, but a view from one of the key players in this field is instructive - it reflects acute awareness of the rapidly changing context within which this regulatory body operates. The above comment also helps explain how the policy process shapes the activities of professional organisations, as outlined in the preceding section.

The system's view (Easton, 1965) explains how various factors shape the educational system and the role of the participating stakeholders. It does not, however, show in detail how the power of these stakeholders working within the system has changed.

Pluralist perspective on power in professional education

To start with, a view of how influence over CPD is moving away from the professionals:

The requirement that purchasing of education and training should relate directly to the trust business plans raises the question of who owns and controls continuing professional development. Traditionally this has been individual practitioners, professional bodies and statutory bodies but it needs to move much further towards the corporate activity.
(Medical education manager 3)

It is against this background that it is possible to understand how the CPD system is reacting. However, by its nature, the continuing education system is diffuse with multiple providers (OECD, 1995) - some with a commercial orientation and some with less involvement in the market place. I have identified four aspects of the system that support the notion of pluralist power interplay - market orientation, interaction between the education providers, role of resources and the rise of quality assurance in the CPD.

Shift towards market orientation in professional education

One key observation is the ideological shift towards a market orientation in the provision of care services, which has found its counterpart in the educational sector.

All the stakeholders appear to have bought into this brave new world, where money speaks (Wistow, Knapp et al., 1996). Hodgson (2000) notes this move towards a market orientation within the sphere of life-long learning, parallels the situation of professional education, in that deregulation and the increased autonomy of educational providers is coupled with increased regulation and financial controls from the centre. On the positive side it can give the 'consumers' i.e. the professionals greater freedom to choose the type of learning they deem desirable.

Yes but the nurse can pick and choose among all the options that are available and most courses nowadays for nursing are modularised and they are available on distance learning packages so there are enormous opportunities for them to go for any module they choose just to enhance their skills in one particular area
(Nurse education advisor 1)

I have also shown before how the intermediate group has entered the market and is influencing the behaviour of the education providers (see for example page 222). It is notable that at the highest level in the health service and the higher education sector, the language of the market appears to be shared:

The CVCP recognises that the NHS is committed to securing the best value for money, taking account of price, quality and market considerations. This will normally involve a competitive process in which tenders are evaluated by the education commissioner against a range of criteria but which ultimately will be concluded through a negotiated contract between the two partners. The NHS Executive acknowledges that this is an onerous process for institutions of higher education but one which is necessary in the interests of fairness and accountability and to secure the best value for money .
(NHS Executive, 1995e)

The challenges of responding to the imperatives of market forces is acknowledged, but the harsh reality cannot be kept at bay - there is an implied threat to the survival of the HE institutions. The new system has developed entirely on market principles - demand and supply are the current currency of exchange (Stanwick, 1994; Pratt, 2001). Another way of characterising this change of professional education, is to see it as entering a post-technocratic mode (Bines, 1992c), in which the purchasers or professionals play a determining role in curriculum design.

Interaction between the education providers - competition or collaboration?

The question arises - how much competition is there? Is there any evidence of collaboration? The competition for custom, as seen from observing the actions of diverse stakeholders, is considerable; living in the educational jungle sharpens the survival instincts.

Note there is a potential danger of overlap of activities of primary care education centre that will result in competition with GP tutors, nurse education provider, conflict with GP Regional Advisory structure and academic unit of general practice. It has a need for independent survival - the economic imperative is paramount - but where does its loyalty lie? Its independence poses usual problem with such a small educational outfit.

(Field notes - Health authority education advisory group meetings)

The unit in question was established for the express purpose of providing a wide range of courses for primary care professionals. As it had a duty to become self-financing within three years of its inception, inevitably it had to muscle into the existing market.

A call for collaboration is not far away, nevertheless:

It's a whole territorial game (between the education stakeholders) starting again as to who's got the best slice of the cake and so on and that takes a lot of time and energy to deal with that and if you're going to have a good outcome you have to defuse the territorial nature of the relationship fairly early on and make people see there's a common aim.
(GP educator 1)

This view carries both pragmatic and idealistic undertones. Some degree of co-operation might be useful, especially as there is frequently an overlap of personnel between different education providers. The idealistic stance is congruent with this respondent's view of the purpose of CPD, which is to help the learners achieve better standards of clinical behaviour. Therefore who the key provider is matters less than the desired outcome.

How have these features of the market place altered the role of the educational provider? In a changing environment it has to respond flexibly. It needs to assess the real learning needs, and provide innovative courses and ideas - such as support for distance learning, modularisation, service orientated learning and IPE (Humphreys, 1994). As Becher (1996) noted, this is a Europe-wide trend. To this end there is a need to collaborate with other stakeholders and education providers to work towards a partnership in provision and accreditation of courses. However, Cameron (2001) warns that the accreditation process, driven by the exigencies of professional bodies, is problematic and can undermine academic rigour.

The learners can accumulate transferrable points or can have their prior learning accredited:

Because of the way the continuing education is arranged, a lot of the colleges have locked those modules that they offer for skill based learning into degree programmes so they can give small amounts of CATS out for each individual one and if a nurse wishes to accumulate them to go on to further study.
(Nurse education advisor 1)

This approach is to an advantage to all concerned - the providers can enter the market place with what appear to be new offerings and learners have an opportunity to choose the location or type of learning. APL and APEL processes (Trowler, 1996) have been particularly useful, as they allow more longitudinal, cumulative learning to be consolidated into a degree.

A desire for higher degrees has resulted in a number of universities offering Masters courses. These have become popular among professional staff wishing to acquire a greater breadth and depth of learning congruent with the aim of CPD, namely to equip practitioners with new insights and skills, which will enable them to take on new roles. One such example occurred within the context of what one could call a defensive move by two independent institutions:

A new development is linking the medical school with the local Institute of HE that will house the nursing college. This was necessitated by the medical school's political awareness of being under threat, as it witnessed establishment of other 'mega' medical schools. The solution was to combine and to create something unique with the nursing college. They are currently planning some undergraduate common learning modules and some new interprofessional Masters degrees.
(Nurse educator 2)

To combine forces is seen by these two players as a necessity in the market environment. Any new developments then can be assumed to have a better chance of success as their market share will be larger. This observation is characteristic of new courses that develop as a coincidence of two forces - demand from below for higher degrees, and the higher education sector seeing an opening in the market. Similarly the spread of NVQs, as discussed already, is representative of the climate of opportunity - the government has provided a legislative framework, the employers desire these marks of achievements and the learners are keen to progress in their occupations (Otter, 1996).

One feature of collaboration is to make it easier for learners to profit from learning that occurs at multiple sites, including their workplace (see also the previous chapter's discussion on work-based learning).

We're actually in the process at the moment of negotiating with the local University for accreditation for CAT points, because we have a lot of in-house courses but they've got to be ratified by an external examining body, because whilst they've been ratified for internal training by the trust board and by the directorates of medicine they've still got to be ratified by the university and we don't actually foresee that as being a problem.
(Nurse educator 1)

Whilst it might seem that higher education in this process is giving up some of its power, another interpretation is possible. The inevitability of competition forces it to enter into a partnership with another provider, in this case a hospital trust, which in return allows the university to put an imprimatur on their education product. Further, it can be assumed that it might through these means entice the learners to take up further credit bearing courses at the university itself, with clear benefit to its bottom line. However, as Brennan et al (1996) note, the road of collaboration between employers and education providers in this instance may not be always easy. On one hand the

educators may not assess individual learning needs properly, and on the other hand the employers are more interested in transferable skills. This challenges the education providers to alter their practices.

The role of resources

Resources, as discussed earlier, are one of the key power instruments employed by all the stakeholders. No wonder then, that from the point of view of the educational system, power - in the shape of funds - is located with the customers, both professionals and employers (see for example quote on page 238 (Nurse education advisor 1). Profit is the prime motivator of the commercial education system and consequently that system needs to be responsive to all the influences in the environment (Stanwick, 1994).

The penetration of market principles into the education system can be seen in a recent publication dealing specifically with the systematic application of marketing techniques and theories to NHS education (Faltermeyer, 1999). As already noted, IPE becomes a commercial answer to the pressures to rationalise - an opportunity to modularise and capture a much larger slice of the professional education market.

Quality assurance

While the quality assurance approach can be seen as one of the power instruments (see above), it is one of the hallmarks of the market, where greater transparency of proposed outcomes and of maintenance of standards is essential to facilitate the 'consumers' to choose wisely.

The colleges are offering the courses and validating them, they're required to have defined learning outcomes and objectives, the usual things that you would expect a course to set up and a proper evaluation at the end of it which acts as an audit too which improves the course for future people.
(Nurse education advisor 1)

The quality assurance process thus assumes greater importance as there is a recognition of the poor quality of much educational provision. There is a clear wish not only to maintain standards, but to continue improving them - the drive for continuous quality improvement is pervasive in the whole of the health service (Joss et al, 1994) and education has to follow suit (Brennan et al, 1997).

A rudimentary formal system of quality assurance exists for GPs in the shape of the PGEA accreditation process. Currently there is no equivalent for hospital specialists or non-doctors. Another approach in quality control is the validation of courses by universities or professional

bodies (such as ENB (ENB, 1990)). This applies mainly for nurses who are thus able to accumulate credits.

One of the important features of the quality assurance process, that came out in this research, is the recognition that it cannot occur in a vacuum. All the interested parties need to take an interest and shape it to achieve the desired outcomes.

The people involved should see to it that the education they are providing (as it exists at present or as it is being modified) is as effective as possible. Systems need to be developed for evaluating, monitoring and for quality assurance. These systems need to reflect the educational strategy and be satisfactorily implemented through wide consultation and ownership. The Centre should verify and accredit educational provision within its remit, exploring the utilisation of NVQs and CATS ratings.

(Health authority education advisory group minutes)

The use of the word 'system' suggests the close interaction between the purchasers, providers and consumers of professional education. It further implies a series of feedback loops, both positive and negative, that are designed to change the functioning of the educational part of the system in an appropriate direction.

The impact of the educational market

The impact of change has been mixed. There is evidence of negative as well as positive outcomes.

On the negative side it was noted that changes create confusion and difficulties in planning, with a loss of continuity.

What I'm saying is that if you reorganise the health service every year for three years, then it's very difficult to set contracts and then monitor them effectively, because the right people aren't in place. People who worked in the first year to identify training needs and then to indicate those to Region may not be the same managers who are supposed to be releasing people to go on those courses the next year.

(Nurse education advisor 2)

This raises questions about the degree of change possible if a genuine educational market is not fully established. Such reality constraints provide limits to the power of the change agents. This 'change fatigue' has been noted in the health and social services, where beside the organisational difficulties it engenders stress in staff (Leese & Bosanquet, 1996). It is easy to see that the wish to purchase tailor-made education might not be easy under such conditions.

I noted the multiple demands and the increased complexity within which the educators have to operate:

One of the issues identified was the constraints and various pressure that impact on GP Tutors from needs of service providers, focus on audit, competition with other learning providers (such as pharmaceutical companies), pressure to organise educational need assessment coming from FHSAs and Government directives and so on.

(Field notes - GP tutors meetings)

A question needs to be asked at this point. Are these members of the educational establishment sufficiently skilled and supported to respond adequately to such pressures? Or would they take the line of least resistance and do the bare minimum?

On the other hand a number of respondents saw a change as an opportunity to develop education by the well-organised effort of individuals with a vision and innovative ideas.

Because of the new (GP) contract in 1990, there was a need for a new programme for people to get their PGEA. We had a lot of different things going on, we had a multidisciplinary education group for practice nurses and GPs, for practice managers and GPs, we had a whole string of things going on, distance learning and so on.

(GP educator 1)

It is possible to see the beginning of the blurring of professional boundaries, occurring in the group of educators, who are capable of working in a flexible manner across such professional boundaries. It can be anticipated that modelling teamwork in this way would be a powerful tool for change. Other innovative approaches include the use of PEP and portfolios (Royal College of General Practitioners, 1993). In a number of places the introduction of other professionals to work as educators in CPD, such as those with a background in sociology, anthropology, and art, has begun, even if professional prejudices can still surface. As I noted at one meeting:

The medical sociologist who worked as a part time VTS course organiser, was trying to clarify in her mind what are the boundaries between undergraduate teaching and post-graduate teaching. It was clear from one of the GP tutors that he regarded her as: "you are not one of us". So whilst he was telling her that she needs to learn and respect the GP on the ground he in fact was telling her that she had no capacity for such skills without really finding out about her ideas and perceptions.

(Field notes - GP tutors meetings)

In summary, the educational system has entered the era of the market with all its advantages and disadvantages. While it had to learn to be more adaptable and responsive to pressures from above

and below, some of these pressures have created increased stress and changed the approaches to learning provision and employment of teaching staff. The customers, at the same time, are learning how to use their financial clout to achieve and fashion a more relevant educational fare.

8.3 COMMENT

The analysis presented in the above section has shown the complexity of the interactions and motivations of key stakeholders in CPD and IPE. Consequently, all the chosen models of policy-making and power were used. I have suggested that the hegemonic model of power explains most accurately why management (in the shape of the state and the employers) is taking an increasing interest in CPD and IPE. However, the existence of multiple providers of education and diverse interests within each stakeholder group and subgroup militate against a simplistic scenario. Such competition is more characteristic of the pluralist model. In addition, the complexity of other influences within the whole of the welfare state allows the systems model to offer a useful perspective.

What message can be drawn from my analysis so far? The recurring theme, rehearsed extensively already, concerns the shifts in relationships between three principal stakeholders - the managers (with the intermediate group included), the professionals and the educational system. I have looked at these shifts from a number of angles, and the message appears to be the same. As more power is assumed at the centre, as more demands issue from the government, the other parties have to continue to adjust their values, their world views and behaviour. While the situation is fluid, nevertheless the independence of professions is being eroded and the education system also finds itself under pressure to respond to market forces.

8.4 THE POSTSTRUCTURALIST PERSPECTIVE ON STAKEHOLDERS

This section of the chapter takes a different perspective on the actions and interactions of stakeholders, and on issues of power and policy-making. The analytical method, discourse analysis, is described in the Chapter Six and draws on Foucault's concepts as outlined in Chapter Five. The purpose of using this method is twofold: the first intent is to triangulate the findings outlined in the first half of this chapter, and the second is to get 'under the skin' of the situation described, so as to understand the deeper working of the whole system.

An approach to an interpretation of the results

Each stakeholder group is looked at in turn. The principal sequence of discussion concerns the components of the discourses (or building blocks), their manifestation and impact. As mentioned in Chapter Six, I blend the analysis of text, discursive practices and social practices when outlining these elements.

The issues of interaction between discourses, power and policy-making are examined in detail to discern the types of discourses prevalent in the CPD and IPE field. The key argument I present here is that there are three discourses, namely the discourse of management, the discourse of excellence and the discourse of adult learning. While each of them is more prevalent within a specific stakeholder group, I have found that all of these discourses are used across the board. I trace how these discourses have shaped the behaviour and thinking of the stakeholders and the structures within which they act, but also how the discourses are influenced by the stakeholders and the wider society. My main argument is that these discourses are a manifestation of the discourse of power that permeates society and influences the behaviour of its constituent parts.

The reader by now will be aware of the main direction of my argument about the shift of the power away from the professionals. Whilst I need to be conscious that my stance might be biased, and I will reflect on it in the next chapter, the critical analysis presented here is my interpretation of the data and is open to scrutiny.

8.4.1 Management and education - the discourse of management

Emergence of the discourse of management

How has the management discourse emerged? It is necessary to identify the principal factors moulding and defining it. According to Usher and Edwards (1994), modern management has adopted the humanistic psychology approach, nowadays termed Human Resource Management. Its overt aim is to enhance the development of an individual within the framework of company needs, by using person-centred techniques. This trend has already been noted in this work. While it can be argued that these notions developed within post-Fordist organisations that needed to be flexible and responsive, the solution is thoroughly modern, in that it appears to provide a technical solution to dilemmas embedded in the exercise of power. The hegemonic view of power fits with the motives of the managers - to standardise performance and to break down the professional barriers hindering the service from functioning more smoothly. As will be seen again and again the discourse of management is absorbed by professionals, as the example below shows. This is taken from the minutes of the advisory group.

A main problem lies in the fact that doctors are trained to work in a hierarchical structure. Getting to the point where decisions can be made in a more egalitarian way is a challenge. Movements in this direction need to start early. Professionalisation, however, tends toward compartmentalisation and acting out of self-interest is a defensive reaction to a perceived threat.
(SCOPME meeting minutes)

This self-critical view comes from a medical educator, who appears to focus on one aspect, decision-making, as an aspect of the efficient functioning of the hospital trust. In the view of modern management thinking, with which this comment is congruent, hierarchical structures are not suitable for a fast-changing environment (Luthans, 1989). Of interest is the diagnosis of the origin of the problem. It is professionalisation, the route of developing an individual professional, that is seen as inimical to the desired goal of more equal communication. Thus the polarity is stark - flexible organisation good, professional identity bad.

The intent is rationalist. It is to remove power from the professions, whose approach to service management has been deemed inefficient.

The Foucauldian perspective on discourses and power offers a complementary explanation. The role of the welfare professions is to contribute to the control of the population through the use of disciplinary power (Foucault, 1979a) and bio-power (Foucault, 1979b) (see also Chapter Six for discussion of these issues). They in turn need to be an integral part of the system. Johnson (1993) bases his analysis of changes in the power of professions from 1980 onward on Foucault's concept of governmentality. This incorporates a notion of professions being an embodiment of expertise required by the state, where professions such as medicine take on the role of mediating the governing of the state through ensuring the compliance of the population with the state's need for law and a healthy and productive population. In consequence, as he notes (p143), the professions were 'both the progenitors and the beneficiaries of this complex network of governmentality' and the professions assumed autonomy (albeit sanctioned by the state) as an integral part of the state governance. Thus the discourse of power is shaped by the needs of the system and moulds the action of the professionals. The new discourse, the discourse of management, reflects much more closely the changing economic fortunes of the welfare state, and a parallel ascendancy of the managerial 'expert' group.

Discourse and control of professions

This discourse now mediates the control of the professions. The professions become an object, 'a workforce'; their characteristics, skills and abilities become a subject of classification and of

measurement, through 'workforce planning'. A hospital trust manager's comment embodies this ethos:

It may be useful to identify what skills and competencies are required to deliver a service and then to assemble the most appropriate team rather than just include people who are already there.
(SCOPME meeting minutes)

Let's note for a moment the use of word 'assemble' and how it mechanises the process of team building. It sees the individual professionals more as a collection of skills, and ignores the human dimension of group interaction. Instead of an organic growth, a Lego-like image is offered.

Traynor (1999) in his research on managerialism suggests that one of the key aspects of the new discourse of management is the adoption of the 'neutral' quasi-scientific language of measurement. The implication is that it is difficult to argue against the logical and objective intent embedded within such rhetoric.

The process of accountability complements the intention to streamline professional action. Yet the implementation might encounter resistance. Here is an observation from a medic, who appears to be seeing the changes in a dispassionate way.

I think we've got a lot of desire for the standard setting, the framework setting, the surveillance, to the setting of targets and performance indicators. I think that's the way the department would like things to go, but whether it will actually happen like that remains to be seen.
(Medical education advisor)

The discourse of measurement has found its target. While the speaker appears to keep some distance from the issues enumerated, the mere fact that they need to be considered, weighed and responded to, signifies an engagement with them.

Thus the professionals are expected to fulfil targets and file work reports. They are under constant scrutiny to perform, and to perform well. Discipline is exercised through the regulation of professionals' movements and use of time. At times the transmission of this message through discourse techniques can be quite subtle.

The practitioners will need to move from a 'one-off' reactive approach to continuing education, to developing a strategic plan for a period of one to two years. Practices are increasingly being encouraged to produce 'development plans'

or 'business plans'. Perhaps these should include plans for the professional development of all staff, including general practitioners.
(Education Board minutes)

The writer of this letter, in his capacity as a manager of funds, wields a substantial power. Nevertheless, this is articulated in a sophisticated way. While the first sentence carries a directive to the recipients (the members of the education boards, who need to implement these intentions), it is set against the backdrop of natural progression - 'increasingly being encouraged' - which suggests, together with the next sentence starting with 'perhaps', a possible line of action.

Value for money (VFM) has become one of the key phrases illustrating awareness of the returns for investment in the health service, may this be for staff costs or education. A circular from the centre discusses this balancing act.

The NHS Executive places the highest priority on securing an adequate number of appropriately prepared health care professionals to meet the long term needs of the NHS and other health and social care providers. However, resources allocated for non-medical education and training are part of the overall NHS budget and must therefore be contained within an assessment of what the NHS can afford. Achieving value for money is a priority.
(NHS Executive, 1995a)

What is the message here? Overtly, it concerns creating an atmosphere of shared commitment to having well-trained staff. However, the next sentence, even if appearing to be rational in its stating of the obvious - that funds are limited - forces the reader to reconsider the previous statement. How wholehearted, then, is such a commitment? Does it create a get-out clause to reduce the education budget?

Discourse of power and its manifestations

Of interest here is the ability of the discourse of power (in this case of one of its manifestations - the discourse of management) to shape practices and structures, and its openness in turn to be shaped by social circumstances. Power is contingent on the forces within the social fabric, but it changes them in the process in turn. As Foucault (1980) suggested (p142):

...relations of power are interwoven with other kinds of relations ... for which they play at once a conditioning and conditioned role, ... that their interconnections delineate general conditions of domination, and this domination is organised into a more-or-less coherent and unitary strategic form...

However, he cautioned:

... one should not assume a massive and primal condition of domination, a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations of domination which are partially susceptible of integration into overall strategies...

This confluence of forces and their potential impact can be seen in a comment from the following interviewee.

I think the intent from the Centre is to try and enable people locally to develop ideas on their own, to pilot initiatives, to think through things for themselves, so that if you've got pressure from above and below, from inside and out, or whatever, so that hopefully it moves the whole thing in the same direction.
(Medical education advisor)

The pervasiveness of the discourse of power is visible in this assessment. The professionals (and the managers) are subject to guidance and directive from above to change and develop the service, but they also are aware of local needs. By assuming the responsibility for change they, unwittingly, fulfil their roles as actors in the game of societal power. As Clarke (1998) suggests, this is one of the current formats of management where managerial discourse is incorporated into the thinking and action of the individuals resulting in (p 241) 'dispersed managerial consciousness'.

The rise of the discourse of management is consequent on a pressure from the population for a more responsive and easily accessible service, the need of society for a more efficient profile of professional action, and a continued desire of the professions to be a part of the governing structure. I have proposed before that the professions themselves have become 'docile bodies' (see also Chapter Five), and consequently these two sets of docile bodies (the population and the professions) are constituted to serve.

Sometimes the awareness of professionals as the agent of control is acute, as demonstrated by following reflection.

And the managers now do it through the use of guidelines and protocols. The culture is not about professional decision-making – it's protocol-based living – and that's the way populations have been so strictly controlled in their lives.
(GP educator 2)

While the speaker might be expressing a somewhat jaundiced view of the role of managers and the subservient role of professionals, the use of guidelines and protocols, as alluded to before, does

carry a dehumanising message. Individuals can be reduced to cases ready to be slotted into predesigned positions. This speaker's overt resistance to the discourse of management does not counteract a proposition that the professions have become docile bodies. The professionals are drawn in inexorably into a different set of relationships with the rest of the service.

It would be in a GP's interest to look at what's going on and make an informed decision about whether or not they're following the norm or whether they are so wide of the mark that they're totally off the beat and within that there will be practice standards and criteria that will be borne out of business plans and referral patterns. Things that GP will gradually get the feedback on.
(Nurse education advisor 1)

The 'practice' of isolationism of general practice is not a current 'norm', according to this interviewee. How do these norms arise? What are the processes that set them up, that define their remit? Is it a need to improve the service or subdue independent professionals? Or are these seen necessarily too much as exclusive categories? I would like to suggest that it is a need for a more efficient service that determines how these structures evolve.

In Foucault's words (Foucault, 1980) (p142):

... power relations do indeed 'serve', but not at all because they are 'in the service' of an economic interest taken as a primary, rather because they are capable of being utilised in strategies...

There is some tension between his formulations of the status of these strategies for achieving a more efficient society and of the driving force of 'an economic interest'. He argued elsewhere (Foucault, 1979b, pp141-143 and Foucault, 1980, pp 170-176) that medicine has become organised as the tool of 'bio-power'. Through this the population can be controlled by curing its ills and making individuals less susceptible to illness through preventative work, in order to make them more productive and predictably available to the economy. A clarification is possible. Foucault (1980) (p99-102) suggested that the 'mechanisms of power', while developing independently of the political will and economic imperative, become 'annexed', 'engaged' or 'incorporated into the social whole'. In other words techniques of power will only persist if they have been shown to be useful to the global interests of society.

Thus political and moral elements of controlling the professionals are replaced by an emphasis on effectiveness and efficiency, as if these were morally neutral categories. This is reflected in the language employed to mould the consciousness of the subjects. Efficiency of service and value for money become guiding principles in organisational life. Professionals themselves are disembodied

by being labelled as resources. When the economic imperative dictates that expensive resources be rationalised, initiatives such as the skill-mix (see also Chapter Seven) start using the language of rationality which removes the personal and individual aspects of the service. They have become 'docile bodies' (Foucault, 1979a).

All of this is happening in the wider context of the change of societal discourses. The market orientation that has permeated the welfare state over the last decade is a reflection of the process of 'commodification'. As Fairclough noted (1992) (p207), this is:

... the process whereby social domains and institutions, whose concern is not producing commodities in the narrower economic sense of goods for sale, come nevertheless organized and conceptualized in terms of commodity production, distribution and consumption.

What impact does this have on the discourse? Fairclough again (p207):

In terms of orders of discourse, we can conceive of commodification as the colonization of institutional orders of discourse, and more broadly of societal orders of discourse, by discourse types associated with commodity production.

Health, in terms of outcomes of the health professions' work, has become a commodity. It is now measured, and the process of converting malfunctioning bodies to healthy ones is monitored for quality. This is evidenced by the wholesale use of the language of quality assurance, or TQM, within the discourse of management (Gill, 1993; Joss, Kogan, & Henkel, 1994; Clarke, 1998).

However, despite appearing to possess less power, the discourse of excellence, which is the discourse of professions (see below), provides an opportunity for resistance to the management discourse. I have noted such a resistance appearing in discussions, as for example in a CPD conference:

The issue of recertification discussed this morning - another part of the same pattern - together with monitoring arrangements/ quality assurance of education. Most delegates were sceptical about need (beside the self-defence vis-a-vis government) or practicality of a valid method.
(Field notes - CPD conference 2)

I have observed that the parameters of the discussion are set by the management: issues of recertification or quality assurance represent the monitoring aspect of the management discourse. The resistance, beside a practical or pragmatic aspect (self-defence) is in negative evaluation of

these innovations. How far this resistance will go is uncertain, especially as recertification or revalidation is firmly on the agenda of professional bodies (see Chapters Four and Seven).

The role of CPD and IPE

Where do CPD and IPE fit into this scenario?

The organisation of continuing education for GPs is one example. Since the introduction of the new GP contract (Department of Health, 1989) as outlined in Chapter Two, GPs have to fulfil specific requirements to receive a PGEA allowance. They need to demonstrate that they have spent on average 30 hours per year spread over three categories of learning activities - clinical updating, disease prevention and service management.

The emphasis on learning how to run the service better, an emphasis that is now codified in the GP contract, bears closer examination. An interest in understanding how the service works has been present for some time. However, the demands of a whole system need to take precedence. This vision is encapsulated in the following quote:

Some principles about sustainable development have become clear - there needs to be a change in emphasis away from individual learning and research towards practice and locality learning and research that facilitates service development.
(Education Board minutes)

The writer of this bid for funds to establish a research network approaches the task with an awareness, that he has absorbed, that general practice cannot stay untouched by wider societal changes. He implies that a much wider and concerted effort needs to be expended to prevent a failure - general practice by implication would become an unsustainable entity. This is one way that the pressure for change is translated into action.

It is notable that it is only since 1990 that the structures to ensure a more systematic acquisition of knowledge and skills have been developed. Why would that be the case? Devolution of responsibility down to the practitioners requires them to be equipped to deal with the complex organisational situations that are a hallmark of the modern health care system. The knowledge thus obtained and developed is linked with the power that works through the professions, and in turn that power and knowledge moulds professionals' behaviour. Devolution of responsibility is coupled with accountability. See for example this quote from the UKCC's publication:

As an accountable practitioner, the UKCC expects that you will be honest when documenting study in your profile. You do not need others to confirm that you

have undertaken study activity. All study, whether formal or informal, needs to be documented in your personal professional profile. This should show your objectives in undertaking the study, its content, duration and relevance to your registration and role. You should also set out what you have gained from the study and how it has met the objectives that you set yourself.
(UKCC, 1997)

The tone of this communication is facilitative. No overt pressure is exerted, indeed the framework appears to be totally devoid of direct scrutiny. However, the format is more controlling than first appears to be the case. By accepting the rules of the game in wanting to continue to be registered, the professionals now have to abide by them. Their behaviour is controlled at distance. Punishment for non-compliance is implied here only indirectly in the proposition that the addressee is 'an accountable practitioner'. The converse, it may be deduced, would result in cessation of registered status.

Accountability for delivering the targets and for maintaining professional competence are devolved down to practitioners, with the managers providing the surveillance framework. This can be seen in how learning needs assessment and portfolio-based learning provide opportunities for closer scrutiny and self-scrutiny. There is a postmodern paradox of greater awareness in action being accompanied by a loss of freedom. This is demonstrated by much greater clarity in what needs to be learned, what the deviancy is from required norms, and better documentation relating to the degree of fulfilment of that requirement. Self-knowledge does not liberate. In addition, education takes on the role of facilitating the adoption of the discourse of the management. The pervasive aspect of this change is evident in the extent to which the professionals begin to use the characteristic expressions of the management discourse, such as 'efficiency' or 'skill-mix'. The adoption of such new uses of language by the professional workforce is accompanied by an alteration of their perspective, which allows commitment to the defined aims of management to develop. The following comment from a medic, albeit one who occasionally takes on a role in the intermediate group, is characteristic of the reproduction of management-speak.

Multiprofessional working and learning could result in organisations becoming more skilled and offering more comprehensive services. The 'Calman' recommendations on specialist training will impact on all professional groups and there is a need to make the most effective use of all available skills as these are a scarce resource. It could be argued that using the skills contained in a team effectively is likely to produce the best results.
(SCOPME meeting minutes)

This portrays a somewhat mechanistic view of professionals - one could be talking about energy or a material resource that needs to be used efficiently. Further, it is the organisation that is the new

unit of activity. Is it anthropomorphising an organisation that makes it easier to take the attention away from individuals?

IPE, as argued in Chapter Seven, can then be seen as a tool to deliver the change in perception and behaviour of the professionals involved. All of this is determined by the discourse of management pervading professional education and behaviour.

Policy-making in CPD and IPE

What is the role of CPD and IPE policies in the governance of professions? One way of looking at the policy-making process from the Foucauldian perspective would be to see it as a result of the crystallisation of power circulating through the system and finding its expression in documents that reflect its potency. This might appear to be contrary to Foucault's observation that power is hidden and that discourses themselves are not immediately accessible. Is it possible to reconcile this tension? The answer, surely, is that attention needs to be paid not only to the policy document itself, but more to the processes of its creation and implementation. In other words, the policy ought not to be seen as an instrument of power, but as an expression of its discourse. And perhaps it ought not to be surprising that this power discourse is permeating the system and that the initiative for change might come from quarters other than management. This is seen in the extract of minutes from a campaigning body for IPE.

We have met with representatives from the Department of Health on several occasions to discuss aspects of interprofessional education, to provide information about its development and ways of tackling the obstacles and to offer our suggestions as to why and how interprofessional education might be supported. As a result of representations from CAIPE and others, the provision of opportunities for shared learning at all educational stages, is now one of the seven priorities which the NHSE has advised education consortia to undertake.
(CAIPE minutes)

Such a policy does not arise *de novo*, but is a result of a multitude of forces acting together. A policy is likely to be accepted when the ground is prepared, when the key discourse has circulated through the system from below, and when it is expressing the orientation of its components, in this case all the major stakeholders. The next few sections contain more on the policy implementation process. However, it is easy to illustrate how the discourse of management has permeated the professional education field. Little disagreement seems likely with the agenda set by the Minister of State for Health, John Denham, in his foreword to the document on CPD that came out in July 1999 (Department of Health, 1999) (p1):

Modern health care relies increasingly on multi-disciplinary teamwork, in hospitals, in primary care and in the community. Teams need to learn together how to deliver modern, high quality and responsive services which cross some of the traditional boundaries of health and social care.

And:

CPD should meet the needs of patients and help NHS organisations deliver their objectives for improving health care...

The message is clear: CPD and IPE have now entered into thinking and practice at the very centre of the Department of Health. The congruence with the concerns and intentions of other stakeholders is shown by the fact that the document was launched at the triennial Joint Postgraduate Medical and Dental conference, whose topic was 'Life-long Learning', and where the three other major stakeholder groups - the intermediate, the professional and the education system - were represented.

In summary, what is the role of CPD and IPE? The previous chapter suggested that these educational modalities help to produce 'docile bodies' through the discourse of competence. This section has shown how the management group becomes involved in this discourse, and how this discourse and the discourse of management work through professional education. I shall return to these themes when looking at the education system and the discourse prevalent there.

8.4.2 The intermediate group

As has already been suggested, the intermediate group is closely identified with the manager group. However, it admirably serves the purpose of analysing the process of policy implementation, as it is at the interface of all the major stakeholders in CPD and IPE. Thus it is of interest to study how power works and how discourses are shaped and developed at this intersection. It is the location where the micro-processes (discursive practices) and macro-processes (social practices) converge. Although I have given in Chapter Six a detailed analysis of their components, I will provide an illustration for each of these processes to set the scene.

A quote from a trust manager, who is involved in the production of an advisory document on IPE and teamworking, serves admirably to show the issues considered during the production and dissemination of a report. This report can be taken to be an expression of the management discourse (arising in this intermediate group).

In fact there is a need to be clear about the target audience of the report. In other words it is essential to have an exact knowledge of the type of people who will be the main fulcrum for change, who will have to make decisions and implement them. What do they think, how do they think, what is the way of possibly changing their attitudes? And also on a pragmatic level people can subscribe much more to change if they have participated in it.

(Trust manager 1)

The effectiveness of a discourse is characterised by the combination of a desire to achieve change and a sensitivity to the field within which the discourse operates. It can be assumed, as it will be targeting a professional audience as well, that the report will have features of intertextuality, in other words a mixture of management, professional and education discourses.

The second illustration is from my field notes recording my reflections on a meeting of an education board.

Observing a creation of a new educational structure for the region. Again showing slow but steady progress - note creation of an idea (later re-enforced by Dr T's action - a whole raft of lectures and presentations - at GP Tutor's conference, at GP tutor's meeting) - frequent repetition will make it truthful - all begin to accept the structure as an reality. It is clear that not all ramifications and implications have been thought through.

(Field notes - Education Board meetings)

This is a very clear example of how the discourse is working through its agent(s), where an idea or policy needs to be translated into a reality . The discourse through its constitutive effect has a considerable impact on structures and practices of the educational system, which are intimately linked in this instance.

My thesis is that the emergence of this intermediate group, in all its heterogeneity, is evidence of the creative power of the management discourse. The structures that have emerged over a period of time reflect an increasing need for continuing professional education and its governance to be more formally organised.

The building blocks of the CPD system - the impact and role of discourses

The results show how the system has been shaped since 1990 to make it ready for this change. Which of the discourses contributed to the changes and how did they shape these intermediate structures?

Power-knowledge in the system - need for change

The policy implementation process involves the production of documents that enunciate the strategic vision and enumerate the tactical steps for the introduction of change. A good example is the establishment of the educational consortia (see also Chapter Seven). These were clearly conceived as necessary structures for better planning, co-ordination of professional education with the needs of the service, and more effective purchasing of such education from the providers. The increasing complexity of the service provision, the need for a more unified approach to the planning of professional education, and difficulties in dealing with multiple providers with a sufficient degree of negotiating strength called for the development of such structures. What follows is an extract from one of the Executive letters that have shaped the development of the educational consortia.

We need to secure maximum cost effectiveness and value for money in all education and training investment. When contracts come up for renewal, education commissioners will be expected to explore the scope for reduction in the cost per student in real terms. In particular, where increases in the volume of commissions are planned, it should be possible to secure some, at least, of these at marginal cost.
(NHS Executive, 1995a)

On the back of the rhetoric of efficiency and value-for-money, education is brought into the same framework of thinking. Education has become a commodity, to be bought and sold. Within that discourse one can negotiate, drive hard bargains and take one's business elsewhere.

The power/knowledge in the system has created a receptive ground for policies that formalise the recognition of these problems. This is another example of how societal power finds expression in shaping the local preparedness for change, paving the way for the policies to be acceptable, and initiating such policies. As Foucault noted (1980) (p 159):

The summit and the lower elements of the hierarchy stand in relationship of mutual support and conditioning, a mutual 'hold' (power as a mutual and infinite 'blackmail').

Thus we can see the raft of documents emanates from the centre, is adapted to local needs and is disseminated to all the relevant stakeholders.

The supremacy of the language

The deployment of language is highly significant. The documents talk of a shared vision, a common culture, a need to speak the same language - in other words, the language of management.

The extract from an education board plan is located in a time when its future function is uncertain. Nevertheless, it sees itself as playing a useful role in shaping the current and future educational agenda.

With the introduction of national and regional changes referred to above (Primary Care led NHS) it appeared that education 'Boards' could offer the local cross-agency steering groups which might -

- i) develop a shared vision of the key characteristics of the future GMS and primary care workforce and an understanding of what the primary health care education system needs to deliver
- ii) set priorities for reshaping local education and training expenditure and effort in the light of national, regional and local priorities
- iii) inform the development of education/training development plans within the Board's constituent organisations and promote the development of joint plans when appropriate.

(Education Board minutes)

The document here presents a picture of issues that surely form a shared context, to which all the parties can subscribe. With this device it begins to build up a structure that would be a logical solution to the challenges ahead. Thus it is positioning the producer of the document as a legitimate contender for a lead role in the change process.

At the same time there is an admixture of the discourse of adult learning. This is not surprising as the management finds contributions from the various discourses useful to achieve its aims. In advance of a more detailed discussion of the adult learning discourse, two examples here look at how such intertextuality works. The first quote is from the minutes of an education advisory group. This educationalist is expressing his views on the educational process.

People's perceptions of developmental wants and needs can differ, and sometimes be in conflict. Differences should be negotiated, priorities established, and an action plan agreed through shared understanding between all the parties involved.
(Health authority education advisory group minutes)

Listening to the advice of this commentator signifies this committee's wish to identify a working model for facilitating change. The view articulated here of the learners is benign, and suggests to the other members of the group that a respectful approach to developing a learning plan ought to be undertaken. Of course, within this rhetoric of respect is encoded a recognition that perception of priorities might differ - what the balance of power at the negotiating table will be is unclear.

The second quote comes from a circular letter from a new manager at the regional office to the constituent education boards he is responsible for.

I see my role as mainly that of a co-ordinator and a resource, keeping in touch with what is happening in different parts of London and enabling people to learn and borrow from each other.

In order to keep up to date with what is happening I would be very grateful if you could I copy to me the notes of your meetings and anything else which will enable me to keep in touch with what is happening in your patch. ...

Another part of the role will be as a facilitator, providing structures (such as the educational workshop last week) for meetings for those from different parts of the LIZ who are addressing a common problem or working on similar schemes. If such meetings are to be successful then they will have to address issues and take forms which meet real needs, and I hope to have suggestions of what you think would be useful.

(Education Board minutes)

This somewhat extensive quote, even if addressed to other members of the intermediate group, nevertheless shows the fine balance between the management and adult learning discourses. To paraphrase - 'I will help you to learn, but I need to know what you are doing, so I can help you to move where I think you ought to be'.

The discourse of adult learning is also apparent in the structures designed to facilitate professional learning. Ostensibly, the facilitators of learning - the appraisers, the mentors and various types of tutors - are meant to embody the principles of adult learning. However, here we see them becoming more closely identified with the intentions of the management group. This illustrates the pervasiveness of the discourse of power through its various contributory discourses.

Comment

I need to emphasise Foucault's observation that power ought not to be seen as a malignant force. According to him it takes shape and influences the direction of society's development in order to make it function more effectively. If professional freedom is under siege, the end result ought to be the same regardless of where the fulcrum of power is. The educational system needs to adopt structures that allow it to be a more effective part of the whole society's functioning.

8.4.3 The professional group - the discourse of excellence

Two themes are analysed here - the discourse of excellence and the process of constructing the professional and the professional group by the impact of the normalising 'gaze'.

The discourse of excellence - building blocks

The need for professional autonomy - creating docile bodies

The discourse of professions, the discourse of excellence, has been alluded to above. This discourse, emanating from the professions, positions the professionals as requiring autonomy in order to fulfil their societal function. This function, to reiterate, is to be a part of the controlling societal apparatus of power, where professional action ensures the constitution of the population as 'docile bodies' (Johnson, 1993). This can be seen for example in the case of social workers, who whilst holding a strong view of their clients' right of individual choice, nevertheless are agents of the state. As such, especially in the child protection field, they become the conduit for the distribution of norms of behaviour and tools for the detection of deviant action (McBeath & Webb, 1990).

One such area, where it is obvious that the medical profession plays a key role in controlling the population, is public health. Public health allows the state to influence the population in its health-seeking behavior - the bio-power in action (Petersen, 1997). Despite resistance from the population itself, for example the recurrent fiery debates in the media about childhood vaccination, most of the children, or rather their parents, will comply. A commitment to the role of public health is expressed in this extract from a GMC publication, setting out the agenda for the future development of medical education.

Public health, temporarily lost from the vocabulary, has been firmly reinstated as a priority in the planning of medical services in this country and abroad, and the undergraduate curriculum must reflect this important change of emphasis.
(GMC, 1993)

The GMC is a regulatory body and thus its policy documents carry considerable weight. What are the messages contained within? There is an implication here that public health may have taken a backseat recently. It could be argued that the medical profession, despite various incentives for practising preventative medicine (see Chapter Two), may have been less compliant than deemed necessary by the state. An aspect of professional discourse - commitment to autonomy from governmental control - took precedence and became a focus for resistance. The discourse of

power, it could be postulated, then finds its way in reinforcing or recapturing that desired goal. This can be seen in the emphatic language used - 'firmly' and 'must'.

The discourse of excellence is reflected in the classic altruistic view of the professions, which claim a distance from political and economic realities, and whose sole concern is to provide the best service at all times to needy individuals (Wells, 1995). At times this intent can find very clear expression.

The purchaser/provider split is endangering doctors' freedom to make decisions about individual patients on clinical grounds.
(BMA, 1995)

This statement from the BMA may seem to be in opposition to that taken by the GMC statement quoted above. The explanation is more complex. Whilst the above GMC statement could be taken to represent a management discourse, it in fact is a more subtle expression of the profession's need to maintain its independence, even if it means to do the bidding of the state.. The complexity of this position can be seen in another GMC statement.

In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;

(GMC, 1998)

The focus here is firmly on the patient's autonomy and it might be considered as shifting the balance of power away from the medical profession. This is consonant with the move towards a consumerist society, but yet again it is an acknowledgement that for the profession to keep its principal role, it needs to absorb into its framework of thinking changing societal standards. Johnson (1993) suggest that the traditional story of loss of professional autonomy does not stand up to Foucauldian analysis. He argues that the de-regulation within the welfare state introduced by the Conservative Government ought to be seen as re-regulation, even if it (p145) 'had the effect of destabilising the established jurisdictions of professional occupations'. The basic mechanism at work is the politicisation of previously neutral expertise that helped to protect its areas of action - these are now open to scrutiny and debate. In Foucauldian terms the subjects i.e. citizens are rearticulated by taking more responsibility for their health and social care. Thus social control shifts from the direct role of the professions as agents of the state, to self-control by the public.

The link with CPD is clear. For a long time the professions could claim that their motives for maintaining autonomy over their actions needed to be coupled with autonomy over professional education. Only they, through direct contact with the public, and being mindful of the knowledge required for the fulfilment of their duties, could be trusted to define the content, format and direction of professional development and the maintenance of professional competence. See also my analysis of this stance by a GP educator (GP educator 1) on page 194.

The discourse of excellence is congruent with structures the professions have created. These structures have been given the power to regulate the profession, and to allow an apparent autonomy of professional action. This power vested in the professions is linked with the claim to a special knowledge, which if not guarded may endanger the population. The following extract was taken from a review of the function of nursing regulatory bodies.

The main purpose of regulation is, therefore, to protect the public from harm that could be caused by the activities of the unregulated practitioner. The definition that was used in the review of the Professions Supplementary to Medicine (PSM) Act was:

“protection is required over occupations which involve either:
- invasive procedures or clinical intervention with the potential for harm;
or
- the exercise of judgement by the unsupervised professional which can substantially impact on patient health or welfare;
and where such procedures or judgement are not already regulated by other means (for example through supervision, or other means)...” (J M Consulting, The Regulation of Health Professions, 1996)
(J M Consulting Ltd, 1998)

From this one might infer that the professionals are a potential danger, and that they need to be controlled. From professions' point of view, it is more about admittance to a privileged club, which excludes the others - the unregulated, those who have not 'bought' their entry ticket. The language does contain a degree of paternalism, such as 'to protect': it is implied that the regulatory body, by exercising this function, will be able to reassure the public that the professionals are to be trusted to act in their interest as they possess a particular, specific knowledge. This is ensured through the process of 'examination' (Foucault, 1977).

This is the knowledge that goes beyond academic sources. This knowledge, as has been rehearsed, is gathered during the process of examination and confession of the individuals using the institutions of the welfare state, where the information thus gathered helps to classify, rank and

thus control them. There is a need to look carefully how this aspect of professional discourse manifests itself.

Medical education must strive to comprehend all aspects of human disorder.
(GMC, 1993)

On the surface the sentiment contained here is admirable. Professionals not only need to keep up-to-date, but they need to extend their horizons into understanding the manifold facets of human life that might cause suffering. But the question is - what are the limits of medical intervention? Is indeed the medicalisation of life proceeding too far (Illich, 1977)? A balanced view gets an airing too:

The scientific process of classifying phenomena into groups is not the only form of scientific method and one of the advantages of the way primary care is organized in the UK is that a combination of individual and population perspectives is possible.
(Royal College of General Practitioners, 1996)

The commitment to science expressed here, whilst being balanced with an interest in individuals, is interesting. It amounts to gathering data and classifying the population and the resultant scientific knowledge can then be shared with others. I am not for a moment arguing against the science, rather, I am trying to illuminate the professional discourse and the extent of its power.

Interpenetration of discourses

The discourse of excellence has hitherto permeated welfare governance. However, since 1990 the discourse of management has taken on a much more dominant role in the welfare state. Whilst management now blends both discourses, professional self-governance receives less emphasis, and in reality the discourse of excellence is used to call the professionals to account (Clarke, 1998). After all, they have propounded the norms of excellence and the standards that need to be maintained. However, it is now the management, not the professions, who define the value of these standards, at least to a large extent. A training manager from a hospital trust encapsulates this perspective.

There are opportunities to shift the emphasis of education and training away from simply fulfilling professional requirements to skill staff to do the job that they need to do. There can be a more direct relationship between patients' needs, service developments, skill mix requirements and how we quickly turn one kind of practitioner into something else to deliver a good service.
(SCOPME meeting minutes)

The professional requirements, i.e. the attainments of appropriate standards are not seen to result in a required range of professionals. These standards are seen as an obstacle that needs to be removed. The discourse of management leaves its spoor here: 'skill-mix' and 'turn ... into' imply a mechanical view of practitioners by drawing parallels, say, with wood-carving. In the process, as Clarke (1998) observes, the professional discourse becomes marginalised. Wells (1995) notes that a conflict between these two discourses can cause considerable tension in practitioners as they represent different conceptualisations of care - individual and holistic versus population and outcome-oriented.

It is telling how much the discourse of management has been taken up by the professional bodies themselves, in what might appear to be a defensive move. In a Foucauldian interpretation this means that the professional bodies are shaped by the coursing of power throughout the system - as they play their role within it they are not independent entities. The advent of PREP by the UKCC serves as an example of this.

We've now got those new requirements (for continuing registration with UKCC) into legislation and they came into force on an incremental basis from 1 April (1995) and the big difference is that now, if you don't meet the Council's requirements, your registration lapses and of course with a lapsed registration you can't practice.
(Professional body officer 1)

What is highly relevant that it was the UKCC itself that has pushed for this legislation. In other words, the management discourse has worked through this organisation without any apparent pressure from above.

Impact of discourses - Constructing a professional

A structuralist flavour emerged from the analysis of the data. Both the professionals and the professions (or their professional bodies) appear to be constructed by the other stakeholders. What role does the normalising gaze play here?

The professional as a learner

The gaze from the management perspective is congruent with the management discourse. Education's purpose, within this discourse, is to make itself responsive to service needs. Consequently the professionals are required to submit themselves to the education initiatives deemed relevant by the managers. The enunciated norm is the compliant professional, who is

defined by this normalising gaze. See for example comment in SCOPME meeting minutes above. A slightly more co-operative view comes from a trust chief exec.

Responsibility for continuing professional development rests ultimately with individuals and their employers. They are the ones who have to 'deliver the goods', ensure conformity to statutory regulations and be publicly accountable for their performance; professional bodies can set the standards and audit participation but do not carry the ultimate responsibility for achievement.
(SCOPME meeting minutes)

Even though the individuals appear to have an equal voice in this scenario, de-coupling the professionals from their professional body is relevant. The primary accountability shifts to the employer who plays the tune. The gaze emanates from the machinery of state via the trust management. The incentive for the managers is to absorb the professionals into their world - after all the professionals have to deliver the goods, for which the managers are accountable. The strategic allegiances have to change.

The inefficiency of professional freedom of choice and decision-making vis-a-vis education identified by the management is without any doubt behind the introduction of the more controlled system for CPD outlined above. There is some justification for this stance. It has been shown repeatedly that substantial numbers of GPs will undertake learning in areas considered hobbies, rather than in those which could improve their performance (Kelly & Murray, 1996). This somewhat jaundiced view appears to be present throughout the system.

It seems that the PGEA have made more people go to educational activities but it was very much for the allowance, I'm sure they do read a lot and some have always done distance learning packages, not many, but on the whole it would appear that professional development is not upmost in their minds, as it were, it's something that might happen incidentally, or it might happen because they're doing a PGEA, but it's not something that they ever think about, sit down and plan in advance.
(Primary care researcher)

What can be discerned if we look behind the surface presentation that slots GPs into the pigeon-hole of pragmatic, money-oriented people? Another site for a resistance to management discourse appears. In response to being obliged to comply with the demands of the PGEA system, they subvert it by playing by the letter, if not the spirit, of this system.

The professional as an educator

I now turn to the professional as an educator. This role is shaped by competing discourses. The discourse of adult learning is expressed through a liberal definition of professional education,

where choice and autonomy of action (as will be seen later) are the hallmark of a professional. On the other hand, the management discourse is demanding a more outcome-centred education. The freedom expressed within the adult learning discourse is unacceptable to the management group, as they need a cohort of professionals who are much more closely identified with the state apparatus. This conflict surfaced during a discussion that involved managers and educationalists.

Leaders in education are more concerned with training and leaders in the higher professional context have a role in helping to realise the learning agendas that learners have set for themselves. Managers, however, have to ensure that the organisation meets its targets and delivers its product to a specified requirement. (SCOPME meeting minutes)

The professional education leaders' role here appears to be shaped by the adult learning discourse, where individual development is paramount. Yet a hint of management discourse resonates in the expression, 'training'. While this word, somewhat unwisely, has been used in professional education, its emphasis on reproducible behaviour might be hidden to the users themselves.

The corporate goals set the norm for education provision and for the function of the professional as an educator. The discourse of adult learning is found wanting, and the normalising gaze enhances the system-linked behaviour. Professional educators are being brought into closer governance of their colleagues. The tensions they might experience are the result of the conflict between these two discourses. I noted this shift of role definition within the cohort of GP tutors:

So what is the role of GP tutors in this context of change ? Whilst they may be critical of changes, they are acting as agents of change by transmitting the ideas, educating critically the GPs to alter their perceptions and a building up a culture within which there will be a paradigmatic shift - the GPs being in the driving seat (the primary-care led NHS).
(Field notes - GP tutors meetings)

Having a dual perspective, not surprisingly, produces a inner tension. However, the process of being shaped by the external gaze is proceeding apace. Whatever resistance might be present, the tutors are working to influence their fellow GPs to take on more responsibility.

Constructing a professional body

How can one postulate the creation of a professional body as a result of the discourse of excellence? According to the type of body, it can be profession's organ of governance (e.g. GMC), representation (e.g. RCN), force for improvement (e.g. RCGP), or a combination of these (e.g. BMA). All the above types of professional bodies would have emerged through the process of a

given profession becoming a locus of societal power. As the discourse of excellence carries with it a need for the profession's autonomy within the state apparatus, the governance of a profession (including a need for improvement and of being a representative body vis-a-vis the state) needs likewise to be relatively independent from the state apparatus and close to the profession.

The discourse in the shape of activities designed to enhance the standing of professions has been looked at already. Another aspect of the power-knowledge impact is apparent in the interaction of these bodies with other stakeholders. One such example is the role of the Royal Medical Colleges in inspecting the training jobs for their suitability.

Inspection visits by statutory organisations should be a genuinely positive experience, working together to achieve improvement, drawing on the organisation's experience and networks. At the same time, the organisations need to see that standards are maintained.

(Professional body officer 4)

The smooth working of the power discourse finds expression not only in the rhetoric of this contribution, but also in how it allows two organisations (i.e. the college and trust) to work together. The discourse of excellence has an upper hand in this encounter: the emphasis is on ensuring appropriate standards for postgraduate training. But is this push for a better educated elite contradictory to the move to dilute its power? One possible interpretation is inherent in the trend for medical specialists to shed a number of tasks that then can be taken up by the other professions. In this way, the population can be controlled more effectively by those who are the subject of management direction, i.e. the non-medical professions.

Further, the improvement role of the professional body is reworked beyond the traditional remit of the maintenance of standards towards a closer integration with the governance process within the welfare state (Johnson, 1993). The normalising gaze specifies new norms - a compliance with workforce planning and a need for an effective use of resources. Professionals are seen as deviant, not conforming to these norms, and their freedom is an obstacle to the effective running of the system. As a result, a greater degree of surveillance has been put in place, and the norms for the conduct of the professional bodies is being specified from the centre under the guise of a drive for efficiency. How effective is the discourse of management in this regard? An interesting example of such a success is the degree of involvement of professionals in forming such norms through their participation on government advisory groups.

Each system of care will require a well-founded central strategy, using national protocols for the investigation and management of patients which are efficient and

effective, practicable and affordable and whenever possible evidence-based. Colleges should be prepared to take a leading role in preparing national guidelines and in keeping them up to date.
(Standing Medical Advisory Committee, 1999)

The change of practices of medical colleges outlined here builds on a proposed logical argument that is measured and ought not to be contentious. Having thus set the scene, it would be difficult to argue against the consequences for the colleges' responsibilities.

In addition, professional bodies are charged, together with other stakeholders, with the role of surveillance of the CPD process. In this way they are brought into the surveillance apparatus of the state. Their autonomy and the autonomy of their members is under threat. This can be seen in part in their co-operation in the quality control of professional education (see also below).

8.4.4 The education system - the discourse of adult learning

Two themes are explored here. One concerns the discourse of adult learning and the second how the education system is constituted by the various discourses converging on it.

The discourse of adult learning - and its components

It has been noted already that the discourse of adult learning plays an important role in the field of professional education and is one of the forces shaping CPD and IPE. With its aims of respecting the learner, of linking learning to experience and of foregrounding group learning, the adult learning approach aims to give more autonomy to the learner and to create a more equitable relationship with the facilitator. These were indeed the building blocks of this discourse which appeared in the data. We have already seen how in the management discourse the learner and her autonomy is, by and large, not respected. Here, a different picture emerges.

Training sessions together are OK but there is a need for a follow-up, for an individual support to professionals to check what they are doing. Then you achieve change, as each professional has a need for a follow-up in a different way according to their personal situation - thus my approach can be adjusted.
(Team facilitator 2)

This comment comes from a social worker employed in a project to introduce Community Care. Her role was to facilitate communication between GPs and social services. As she found early on, much learning had to take place within both professional groups. Respect for a learner here has a number of facets - foregrounding the individual versus group learning, learning as a factor for

change, and the need for an individually-tailored approach. A link between learning and change is clear, and it implies the commitment of both learner and facilitator to a type of learning that is relevant. Elements of the discourse are congruent with each other.

The issue of where power resides in the educator-learner interaction is a crucial one. How do facilitators of learning approach their role? Who dictates the tune? A comment from an educationalist encapsulates the 'responsibility' idea - the idea that both parties in that encounter need to adopt a responsible attitude in their respective roles.

Educators need to be leaders in education helping learners to identify their learning needs as well as their learning wants. In this sense, learner-centred does not equate to learner-led. Both parties have to participate in negotiation about the learning agendas and how they are to be achieved.
(SCOPME meeting minutes)

The balance between a free-for-all and management-driven design of education needs to be struck. The skilful facilitator ought to be able to see beyond the immediate wants of the learners and help them to achieve a movement in a desired direction. Tension is inevitable. Are the educators independent, are the learners' best interests at the centre of their consideration, or could they be accused of playing the management's game? Of course, the issue is that a learner's survival depends on being capable of operating in a forever changing environment. Thus a facilitator may need to act as a go-between with the management side (Brookfield, 1986).

Two other elements of the adult learning discourse emerged: one referring to experiential learning, the other to group learning. Experiential learning or learning in-situ, by employing reflection-on-action (Schön, 1983), is deemed relevant, as seen below.

A debriefing period is always necessary following any critical event, simply because the members of the team need to know what happened. They need to know whether the initial treatment was effective; they need to know what the prognosis of the patient was; they need to know how well they did. Unless you reinforce team members of how well they responded, whether their approach was coordinated, what the outcomes of it were - you're just going away without any information and you are not actually getting any reinforcement that you need. Because if there was an error or an error of judgement, one should be able to sit down and say well maybe we should be looking at it from another viewpoint.
(Nurse educator 1)

The link between action and learning is very close. The speaker's words represent a confluence of professional and managerial discourses, that are congruent with the adult learning one - it is so much more relevant to learn while performing one's duties, rather than learn in a theoretical way.

At the same time, the management's wish to improve service delivery marries the professionals' commitment to high standards of professional care. The adult learning discourse finds here an expression in a social practice of the facilitator who feels obliged to engage the learners in an act of reflection. The relationship between them is defined and moulded by the discourse. The above example interweaves valuing the team with interprofessional learning. Without any doubt, a complex situation implied by the expression 'critical event' demands a team effort and team reflection.

Dilemma of adult learning discourse

Is the adult learning discourse without its problems? Is it such a benign enterprise? What are the issues of which one needs to be aware?

The critique by Usher and Edwards (1994) of adult learning theories has been described in Chapter Five. To recap briefly, the main point of the critique is that these theories retain a behaviourist slant by relying on a scientific basis to sustain their call for legitimacy. While the intent is to give a voice and power to the learners, and to enhance their growth, the main if implicit aim is to ensure that the learners will become more effective, more capable of fulfilling their tasks. This is evident in a number of the above quotes.

How has the discourse of adult learning taken root in the thinking and practice of educators and other stakeholders? It could be suggested that the societal discourse of power is speaking through the discourse of adult learning. This discourse is associated with a raft of techniques that have proved effective in present-day society, techniques which favour the individual who can demonstrate flexibility in learning and working over the individual who needs to more rigidly follow learned routines or be under direct managerial control. These (Foucauldian) techniques, well rehearsed already, are surveillance, examination and normalisation. I will illustrate this contention with a quote from my notes of a postgraduate meeting.

The development of Facilitated Needs Assessment approach creates an opportunity for strategic planning of education for the whole system - on short and medium term basis especially as it will be agreed hopefully, that PEP will feed into PDPs.

(Field notes - Education Board meetings)

A number of these techniques find expression here. Needs assessment subjects the professionals to an examination of their deficits in knowledge, skills and competencies. PEP (Personal Education Plan) builds on this assessment and provides a tool for self-surveillance and, in the form of PDP

(Practice Developmental Plan), for surveillance by another authority. Normalisation comes into play as the professionals subscribe to this notion, by accepting it as a normal part of their working lives. The subtle blend, the intertextuality, of the adult learning and management discourses is seen here. Use of the word 'facilitation' is redolent of the adult learning approach, while 'strategic planning' and 'system' reflect an interest in a well-functioning system capable of fulfilling its primary task.

Why has this discourse been adopted by the education system? The answer surely lies in the changing environment in which the education system has found itself. The system cannot be isolated from the 'real' world. It needs to be seen to be responsive to societal changes. Bines (1992c) noted the shift towards the 'post-technocratic' mode of organisation of CPD, where market forces play a more prominent role, and where the power has shifted from the education establishment to the purchasers. The education system has accepted, it seems, these changes, as noted in comment from an educationalist.

There is a need to rationalise the educational provision of the expanding numbers of courses, particularly at post-registration level, possibly with a move towards more multi-professional education, and by the various higher education institutions involved with primary care education so as to achieve equivalence.
(Health authority education advisory group minutes)

The aspect of the adult learning discourse that foregrounds choice (and implicitly respect for a learner) is taking a backseat here. Whilst a diversity of courses hitherto presented opportunities for the learners to choose what suited them, this choice is countermanded by the needs of the education providers to survive in a hostile, competitive environment. In such context, management discourse provides appropriate tools to mould awareness of its users and recipients. The appeal is to reason, and another powerful consensual element enters into discussion here - multi-professional education, a format of learning now favoured by the powers that be. Such arguments are irresistible: and the adult learning discourse, that could provide one set of responses by giving the learner a greater say in the decision-making process, is silenced.

The discourse of adult learning and the field of CPD and IPE

I have argued above that the discourse of adult learning is in use in the management and intermediate group. The reasons are clear. In the Foucauldian view it offers the techniques of power, namely surveillance, confession and classification. These work through power-knowledge to mould the cohort of professionals and to make them more compliant and efficient participants in the grand design of the expanding welfare state. In addition, it has the hallmark of the power

discourse in being mostly hidden, as the professionals are unaware of its impact and how it works through them. These characteristics are linked to a format of professional activity, such as audit.

The course is more traditional now, it is basically didactic teaching, plus project work and some people don't do the project work, so they get points for the didactic teaching and the project work is essentially audit and then all the audit is amalgamated together so people can see how they're doing in comparison with the other people on the course.

(GP educator 1)

Audit in this instance is not a solitary activity, its results are shared with other colleagues. Herein lies its power - the surveillance is both external (i.e. it is located within the group) and internalised by individuals. By sharing the results one becomes ranked, and the pressure, inevitably, is to improve one's performance. An appeal to the competitive spirit, and a wish not to be shamed, hides the motor of the power discourse.

The close identification of CPD and IPE with the world of work, both in terms of content relevance and its location, make these learning modalities amenable to more direct influence by the organised group of stakeholders, that is, the managers and the intermediate group. Thus the cohort of educators concerned with CPD and IPE, while drawn mostly from the professional workforce, play out the congruence of discourses of management and adult learning. This is apparent in the pronouncements from all the stakeholders, whether in policy documents or minutes of meetings and conferences, and regardless of the convening body. Sometimes the admixture is very clear.

Objectives of the educational board include:

- To link education with service needs
- To empower individual practitioners to develop Personal Education Plans within the broader context of Practice Development Plans
- To enable practices and practitioners to internally review process and development
- To ensure sufficient and appropriately trained GPs for local needs

(Education Board minutes)

If we take, for example, the second bullet point, we can see the juxtaposition of the word 'empower' with its connotation of giving power and autonomy, with the movement from Personal Education Plan (PEP) to Practice Developmental Plan (PDP). As argued before, PDP is a management tool. This group of professional educators is setting up its stall very clearly - it needs to work through the individuals by 'empowering' them to achieve the educator organisation's tasks and objectives.

Commodification of professional learning

The action of actors in the education system manifests also in the mixing of discourses. Three such behaviour patterns were noted in the data: the adoption of marketing strategies to promote the uptake of courses, the increased flexibility of organising educational offerings and the increase in quality assurance processes (see further). Education has become a commodity which needs to be sold and marketed, and the consumers wish to see the kite mark (Fairclough, 1993). This process of commodification has been remarked on earlier. I noted this change whilst attending a conference where a number of universities had stands describing their courses.

University as commerce was seen in the documents produced which were designed to attract by showing potential purchasers university's (and by and large 'new' university) ability to deliver what the purchasers of education need.
(Field notes - WBL conference)

The context of the conference is relevant: it addressed work-based learning, and as we have seen already, this is a relatively new venture, whereby employers support continuing education, in this instance university accredited or delivered. Glossy brochures reflect the competitive world of professional education.

Education providers have had to become more flexible in such an environment. Another interesting congruence of three key discourses, as expressed in action, emerges here:

Yes but the nurse can pick and choose among all the options that are available and most courses nowadays for nursing are modularised and they are available on distance learning packages so there are enormous opportunities for them to go for any module they choose just to enhance their skills in one particular area.
(Nurse education advisor 1)

The nurse, as a responsible and autonomous professional, has identified her skill deficit. As an adult learner, she is apparently exercising her freedom of choice, having looked at what might be most relevant for her needs. On the other side of the fence sits the educational system. It has developed a much greater variety of offerings, that makes it easier and more accessible for busy professionals to take them up.

Quality assurance

Quality assurance (QA) deserves closer attention. There is an obvious lack of co-ordinated approaches to evaluating the quality of educational provision and this was identified as an

important deficiency during the data collection. Different stakeholders have differing systems of QA in place, varying in degrees of sophistication and effectiveness. While the university-based courses do benefit from external, even if at times criticised, processes of QA (Brennan et al, 1997), the majority of short courses have mainly informal methods of QA in place. General practice presents a particular challenge, as highlighted by this writer in his letter to educational boards.

Quality assurance in GP CPD currently is inadequate. In an unfettered market, there is a natural tendency for the bad to drive out the good. A practitioner can most profitably meet the PGEA requirements by attending lecture courses catering for large groups which are cheap to organise, or pleasant but unchallenging evenings sponsored by drug companies, rather than by more personally designed and more demanding activity. For many practitioners meeting PGEA requirements is just another bureaucratic hoop to jump through, whatever their commitment to their professional development.
(Education Board minutes)

Quality assurance is needed as two aspects of the appropriateness of GP education need to be monitored - how the learners and educators respectively approach it. The learners, it is intimated here, take the path of least resistance, whilst the educators, in case of drug companies, are more interested in getting punters to listen to their sales pitch, rather than providing a relevant learning experience.

The other problem is a lack of co-ordination between different elements of QA and the adverse effects on the institutions being assessed. These may include surface changes in institutional procedures and increased expenditure on bureaucratic procedures designed to prepare the organisation for an inspection. Thus energy is diverted away from consideration of useful change toward fulfilling the changing profile of external demands. This is acknowledged at the centre as well.

The CVCP and the NHS Executive accept that education commissioners have a legitimate interest in the quality of the educational process and its outcomes. However it is acknowledged that with the number of stakeholders involved the demands for information concerning the process and outcomes of quality assurance measures can impose an unnecessary burden on education providers.
(NHS Executive, 1995e)

This appears to be a very realistic view of the challenges faced by providers. Not only do they need to be flexible, offer new courses, and compete in the educational marketplace, but they also must subject themselves to external scrutiny.

It is possible, of course, to put quality assurance processes under the spotlight of Foucauldian analysis. After all, quality assurance is yet another example of the surveillance apparatus in action. In all its varieties it relies on the collection of data, on classifying subjects according to enunciated norms, and on having a system of reward and punishment in place. This can be seen in the case of the PGEA system alluded to in the previous quote, where the reward and punishment are simply financial - fulfilling the requirements results in receiving a proportion (originally top-sliced) of GPs' income.

Another example of this is the quality assurance process used by the Royal Medical Colleges at the postgraduate stage. It seems to be formed more by the discourse of excellence (the discourse of professions) with some contribution from the discourse of management. These colleges visit the hospital trusts providing positions for medics in training grades. If a specific job is found wanting, approval for this job to have training status can be withdrawn, sometimes with immediate effect. This has a two-fold result. First, half of the funding, provided by the Postgraduate Deans, is withheld; and if it wished to maintain the post, the trust would need to identify appropriate resources, to the detriment of other services. Second, there is a real danger that the medic occupying such a post will have the time spent in it deducted from their cumulative record of recognised experience. Thus it is possible to see how professional bodies have resorted to implementing the surveillance process themselves, on behalf of the state. This is encapsulated by this view from within one such college.

The regulatory visits by Royal Colleges are one way of connecting training standards to continuing professional development as one of the criteria for training approval is the extent to which local educators are themselves participating in CPD. This should be an important lever for change with college members and fellows, translating nationally agreed principles into local action in the delivery of the service.

(Professional body officer 3)

The proposition here is that by targeting the key people, the local educators, it will be possible to implement the desired policy. Yet again, the link between the education and service is underlined. The discourse is coherent to a fault - cascading the desired change from national level to local is now integral to the function of the colleges and the learners, educators and the trusts do not have any option but to participate in this dance. While the discourse of excellence appears to be the motivating power, the discourse of management has influenced its manifestation substantially. Surveillance is power.

8.5 COMMENT

This part of the chapter has used discourse analysis, based primarily on Foucault, to analyse the data. Two perspectives on the data - one in the earlier part of the chapter using the structuralist view of power and policy-making and the other relying more on the poststructuralist interpretation of it - are integrated in the next chapter.

Nevertheless, some reflection on the analysis outlined above is apposite here. The most important finding refers to the three discourses that have emerged, each one primarily forming a stakeholder group and being in turn used and shaped by it. I have argued that the management discourse is the most influential, as the sheer drive for survival forces the educational establishment and professionals to adopt some of the views and values espoused by the management. Or to put it in another way, more congruent with the Foucauldian perspective, the power-knowledge forms the discourses, the related societal institutions, and the subjects of their remit. In the following chapter I will revisit the key tensions and dilemmas uncovered here and will attempt to make suggestions as how these might be resolved.

9 CHAPTER NINE - SUMMARY AND CONCLUSIONS

9.1 INTRODUCTION

This, the last chapter, pulls together all the strands of this thesis and highlights its key contributions. I also provide a critique of my work and of its approaches and offer conclusions. I am not providing a summary of the background issues contained in the literature review, as the summaries at the end of each chapter are sufficiently extensive.

Why did I embark on this journey? As a practising professional and an educator I have been interested in interprofessional education for some time. I have noticed how in recent years IPE has become of central concern for all the key players in the professional education scene. I have identified a yawning gap in the literature dealing with CPD and IPE: that is, little critical analysis exists of the reasons for the emergence of these modalities of professional learning. Consequently four aims emerged:

1. To develop a **contextual framework** of the key issues relevant to an understanding of interprofessional education (IPE) and its place in continuing professional education/development (CPE/ CPD). This requires building up a picture of the changing health care, teamwork and professional education scene.
2. To develop a **theoretical framework** for an analysis of empirical data exploring IPE and CPD and their relevant contexts.
3. To **critically evaluate** the emerging picture of the context of IPE and CPD on the basis of this theoretical framework.
4. To **investigate how IPE and CPD feature** in the thinking and practice of key players, who are identified as policy makers, educators, employers, and the professionals themselves.

To achieve these aims I interviewed a group of key stakeholders and obtained additional data through participant observation and an analysis of relevant documents. The data were subjected to the grounded theory analytical method and discourse analysis.

The two main contributions I have made to the literature of professional education concern the scholarship aspect and the outcome of the empirical research itself. Firstly (and this relates to the study's first aim), I have compiled a literature review of two areas of concern, namely teamwork and interprofessional education, within the context of changes in the welfare state and the wider field of continuing professional education. Secondly, I have undertaken a critical analysis of the move towards teamwork, CPD and IPE over the last few years (this relates to my third aim). Further, I have analysed the actions of stakeholders and the interactions between them in the field of continuing professional education and IPE (this relates to my fourth aim).

What are the implications of the findings of my research? Two stances are explored - one from a dispassionate observer's viewpoint, and the second from a more critical perspective, evaluating the possible positive and negative impacts of these changes in professional education.

First, I want to describe how I arrived at an overall picture in this work and why the research itself is concerned with CPD in addition to IPE.

9.2 INTEGRATION OR DISJUNCTION?

The picture that emerges here needs to be taken as an organic whole, not as a research sequence moving through the setting of aims, literature review, methodology and discussion of data. Instead, there was continuous interplay between research intentions, description of context and the empirical part of the work. The elements of scholarship in the literature review section (Chapters Two, Three and Four) were augmented and informed by the analysis contained in the discussion (Chapters Seven and Eight).

9.2.1 Context of professional education and analytical process

I found I could not discuss IPE in isolation from CPD. While interprofessional education can be and is introduced during the pre-qualifying and post-qualifying stage of professional development, its major role is at the continuing stage. Thus the whole context of CPD, including its current state of development, the form of its provision and its effectiveness, needed to be understood before the role of IPE could be discerned.

9.2.2 Context of policy and analytical process

Similar considerations fuelled the need to establish a dialogue between the wider political and policy context of the welfare state and the policy context of CPD and IPE. I have suggested that it is not possible to understand how policies for CPD and IPE have developed and been implemented without a consideration of the wider social and political contexts.

Another feature of an integrated approach was the need to introduce into the debate current developments in all the fields (NHS changes, CPD and IPE). In this way it was possible to expand the argument by illustrating how the situation is continuously evolving and how the trends identified during the study are taking shape.

9.3 A SCHOLARLY REVIEW OF TEAMWORK AND INTERPROFESSIONAL EDUCATION AND THEIR CONTEXT

In this section I outline the way in which I have contributed to the professional education literature. I bring in reflections from the relevant sections of the data analysis to illuminate how apparently neutral themes in the literature review can be critically interpreted.

In my literature review I have fused elements in a way that is currently lacking in the professional education literature in health and community care. That is, I have brought together an analysis of the policy context of the welfare state, the current state of interprofessional working, the shape of continuing professional education and an up-to-date review of interprofessional education. A more extensive treatment of these issues is the subject of a book, building on this literature review, that I am currently revising for publication. Nevertheless, the review presented here is of sufficient importance to stand alone.

9.3.1 My specific contribution to a review of CPD and IPE

It is the link between the abovementioned themes that allows a more complete picture to emerge of the complexity of the interrelationships between the factors shaping professional education.

A critical perspective on the NHS changes and teamwork

The NHS changes can be understood in terms of policy-making. Whilst the drivers for change are the determinants of the policy process as per the systems model (Easton, 1965) (for example, economic situation, ideology of the party in power, societal pressures), the hegemonic model of

power suggests why the focus of influence has moved away from the professions toward the management class. A need for a better use of shrinking resources brings to the forefront, within the market model of state governance, the more dominant role of managers whose allegiance is towards the state apparatus (Salter, 1998). This is not to deny that the managers have a degree of freedom from central control to be able to respond to local issues, nor that their intent is to provide a high quality service.

The poststructuralist perspective echoes these conclusions about power shifts. Technologies of power, namely 'surveillance' and 'examination' (Foucault, 1979a), allow better control of the professions within the new structures of the welfare state through the accountability processes. The outcome, of course, is to ensure that the professions are in a position to exercise their task of controlling the population through the use of 'bio-power' and 'discipline' (Foucault, 1979b).

The literature review argues for the value of teamwork within the modernist framework. Teamwork is seen as 'a good thing' within the academic and professional community, even if it is acknowledged as having the potential for a negative impact on professionals or clients. A Foucauldian perspective produces a more critical interpretation of the drive towards teamwork. The team becomes a locus of mutual surveillance, an opportunity to transmute the professionals into 'docile bodies' (Foucault, 1979a), and it facilitates power becoming less identified with the hitherto dominant professional group - that is, doctors.

A critical view of CPD and IPE

The two principal analytical perspectives illuminate both the CPD and IPE field in a contrasting manner, yet it is possible to see overlap in the respective conclusions reached. Thus, adult learning theory (and here it is seen as belonging to the modernist raft of theories) suggests that if its precepts are followed, learners can become independent, self-motivating and capable of engaging voluntarily in a productive enterprise (Knowles, 1990a). If adequate respect is accorded to them by teachers and employers, they can actualise their potential and contribute to developments within their field of work. This modernist stance argues that a rational approach to professional education would achieve effective results and that CPD is essential in the fast-changing world of professional knowledge. This rationalist theme underlies the whole set of arguments exploring the potential advantages and disadvantages of IPE, how to approach curriculum development, what factors one needs to be aware of that can determine success or failure in establishing IPE and, most clearly, the need for evaluation of the effectiveness of IPE.

In the poststructuralist perspective, professional education is interpreted as a means of moulding the professions and of controlling them. Also the use of adult learning theories, which might appear to have liberating intentions, in fact allows a much greater control of the learners' behaviour. It does this through encouraging their commitment to ideals of devolved responsibility that carry with them the notions of self-surveillance and service-relevant learning.

In this scenario the state is the locus of the power and uses the technologies of power, namely 'normalisation', 'surveillance' and 'examination' (Foucault, 1979a) in the education process, to further its aim of disempowering the professions. Such an interpretation suggests that societal power will take the shape society requires for its more effective governance. Education is an integral part of this governance. The trend towards accountability in CPD brings the 'surveillance' apparatus into action, whilst work-based learning also provides an opportunity for the managers to control the direction of learning.

The overlap with the modernist stance is striking: in both cases there is a need for an effective workforce, but the difference lies in allocating a conscious motive to an agency. The modernist stance strongly suggests that a power elite develops its policies in response to external forces (economy, influence of pressure groups), but its ideology would still be the conscious determinant of the policy process. The poststructuralist stance, on the other hand, proposes that societal power is more of an elemental force, and that it shapes the structures and actions of the principal actors, even the power elite.

The two-fold perspective similarly showed contrasting views on other aspects of CPD and IPE - for example, the role of educators. Assuming them to be well versed in adult learning theories and practising them competently, do the educators facilitate individual development or are they instruments of control and surveillance? Is the competency movement purely a response to a need for greater transparency of professional action, or a means of producing professional 'docile bodies' through the examination process? Is learning within interprofessional groups an opportunity to learn in a safe environment about each other or, on the contrary, an outstanding tool for blurring professional boundaries through normalisation and examination and thus diminishing the unique professional power-base?

However, an appearance of resistance to such manifestations of power can be understood. The problems in achieving well-functioning teams and successful learning organisations, or in establishing IPE courses that survive for a reasonable time, can be explained by the complexities of power formulation: local resistance is continuously present and power is reconfigured in such

a dialogue. The vigorous debate about the appropriateness of an evidence-based approach in education is another manifestation of resistance to the management drive for cost-effectiveness.

In summary, beside offering a scholarly view of CPD and IPE and their contexts of NHS and Community Care, I have cast a critical eye on these issues. As I argue later, it is possible to accept conclusions offered as a result of different theoretical formulations. Indeed, each of them provides a legitimate view. However - and this point is expanded upon later - it is the Foucauldian view that I believe represents the most appropriate interpretation of the state of affairs.

Now I turn to consider the second major aspect of my thesis - the empirical work concerning the stakeholders. First, I need to refer back to the relevant writing on stakeholders within the literature review.

9.4 STAKEHOLDERS IN CPD AND IPE

This section shows more specifically my contribution to the professional education literature. So far, as far I am aware, no one has provided either a comprehensive description of the policies of the main stakeholders in CPD and IPE, nor an empirical analysis of the actions of these stakeholders using the two-fold perspective on power and discourses.

9.4.1 The literature review - the contribution to scholarship

As a part of the literature review I have looked in some detail at the development of policies in CPD and IPE. Beside providing a background to the empirical part of the study this review is valuable as it brings together in one place three elements. These are: a description of policy development within the principal stakeholder groups; their thinking and motives for getting involved in CPD and IPE; and an analysis of how they interact and shape these educational modalities.

At this stage, five groups emerged as important - the state, the employers, the professions, the education providers and the users. At the time of writing very little has been said about the role of users in IPE¹⁹. I note in advance that the analysis of empirical data produced a somewhat different configuration of stakeholders, and I shall return to this later.

¹⁹ Pioneering work is just beginning to emerge - see Annandale et al (2000) and Barnes et al (2000)

The most remarkable observation emerging from the literature review is the increasing involvement in the last decade of the state and the employers in CPD and IPE. The link to a market-orientated philosophy, that engenders a need for closer ties between the service and education, is evident. Whilst the professions had to adjust their policies to the changing political reality, the initiative has been taken away from them.

Interaction between the stakeholders

I believe that the template that I have outlined for analysis of the interaction between the four main stakeholders (namely professionals, state, employers and the education provider) is novel as it explores all the permutations in a comprehensive manner. Although I mostly draw on the literature, very few sources themselves consider more than one or two of the relationships at any one time. This framework has helped in looking at ways in which the stakeholders respond to one another, and influence each other's respective activities and policies. It also provides an opportunity to trace the location of power within the system.

9.4.2 Analysing the stakeholders and their interaction - the empirical work

Who are the main stakeholders involved in CPD and IPE? The analysis identified four: the management group (this includes the state and the managers in health authorities and health care trusts); the intermediate group (working on the interface of the management, professional and education groups, and primarily concerned with commissioning and directing delivery of education); the professional group; and the education system.

Power and policy-making

I have looked at the policy-making process using the systems model augmented by theories of power, namely hegemonic and pluralist. While taking into account the external environment within which a stakeholder works, the systems model is insufficient to account for the influences of other stakeholders. Use of and location of power needs to be analysed as well. In the steady state situation a pluralist model prevails, where different stakeholders hold nearly equal power and have more of an equal access to decision-making (McCann & Gray, 1986). However, the picture that emerged of the situation at the state level suggests that the hegemonic model, where the government works closely with and through a group or class, is nearer to the truth. In my analysis the power axis since the mid-1980s has shifted from the professions to the management class, with the introduction of general management into welfare services organisations. However, it should

not be assumed that the 'transfer' of power is smooth, that there are no tensions or that the struggle for power does not continue.

Nevertheless, the alteration in power balance is evident in policy-making for CPD and IPE. The state and the management class have taken a much closer interest in these aspects of professional education and demand that it be linked with service needs. This is reflected in a requirement, now enshrined in regulation, for professionals to participate in CPD and IPE and to be accountable for such participation.

At the level of policy implementation (specifically, at health authority and trust level), a pluralist model with aspects of collegiality is more appropriate. To implement decisions, co-operation between the management and professionals is essential, and local policy can be shaped by competing local interests. Whilst this applies to general aspects of service provision, the situation for professional education is different. The hegemonic power perspective is more accurate in describing how the shape of professional education is determined, as the management now has a duty to ensure that the clinical governance framework, including CPD, is in place. The autonomy of individual professionals has decreased. Their clinical decision-making and educational choices are forced to be more transparent as the professionals are required to become a more integral part of the system.

The professions, which have lost their claim to power, now have to behave in a more pluralist fashion, by competing with other interest groups for resources and access to influence at the centre. Temporary alliances between stakeholders with the same interests appear for pragmatic reasons (Johnston, 2001).

A similar loss of power has been experienced within the education system with the adaptation to the realities of the market place. The purchasers of education determine the format and content of professional education with increasing certainty and demand accountability through a quality assurance process (Brennan & Shah, 2000). In order to survive, educational providers respond to these pressures by diversifying their wares and competing with each other (Humphreys, 1994).

Discourses of power

I have identified three discourses prevalent in the field of professional education, that are particularly relevant for CPD and IPE. These discourses are: the discourse of management, the discourse of excellence and the discourse of adult learning. Having suggested that these discourses

represent variants of the societal power discourse, it is now necessary to identify their place in professional education, the changes in their prevalence and the impact they have on educational structures and the thinking and action of stakeholders.

My basic proposition builds on Foucault's concept of the power discourse, which affects social structures, but in turn can be changed by the action and thinking of the social actors and through associated resistance within the system.

Each discourse has close links to a particular stakeholder group, but it is in the nature of the discourses that they are manifest in all the stakeholder pronouncements and behaviour. Thus the discourse of management is identified primarily with the management group, the discourse of excellence with the professional group, and the discourse of adult education with the education group. In line with Foucault, I have suggested that these discourses take on a dominant role according to their ability to achieve the primary societal goal - to create and mould societal structures that allow an adequate control of the population for the society to function efficiently.

Discourse of management

Consequently the discourse of management has arisen in the context of economic retrenchment within the welfare state, where a different configuration of control mechanisms has been required. The professions in recent years were not adequately fulfilling their central societal role of controlling resources and population. Their ability to employ the technologies of power ('normalisation' and 'examination') appeared less effective and they themselves had to be brought under much closer control. The professions themselves have become the docile bodies.

The prevalent societal discourse, the discourse of the market, is reflected in 'commodification' (Fairclough, 1992), whereby a number of social relationships are conceptualised in terms of commodity. The language of quality control, of consumerism, of value-for-money, of accountability, is characteristic of the discourse of management. The emphasis on efficiency diminishes the human dimension of patient-professional interaction.

The surveillance gaze is turned on the professionals. Standards and norms for professional education are set, and their fulfilment monitored and recorded. The emphasis on evidence-based medicine and on clinical governance, where CPD is linked firmly with organisational needs and the monitoring of performance, bears witness to these changes. The hegemony of discourse of the power elite, as Cookson (1994) argued, is evident in the extent to which it shapes the thinking of

the individual actors, who then accepts these norms as their own, and in the process unwittingly circumscribe their autonomy.

Discourse of excellence

The professional discourse, the discourse of excellence, is associated with the notion of an autonomous professional. It has, until recently, been capable of fulfilling the societal imperative for control, and has contributed to the maintenance of an economically productive population through the use of 'bio-power'. In line with that role, professional disciplinary knowledge has served as a means of empowering professionals. The effect of changes in professional 'power-knowledge' is evident in how the operational research, including the understanding of doctor-patient relationships, has shaped professional education.

The management discourse begins to shape the professional one. The need for effective professional action is permeating the professional ethos. One element has been absent in the professional discourse, a concern with finite resources; instead the concern has been with effectiveness, not efficiency. This could explain why the discourse of excellence has in recent years taken on less of a role in moulding welfare structures and professional education. The management discourse challenges the discourse of excellence, as the latter postulate of professional autonomy in clinical decision-making and choosing educational fare is found incompatible with the call for accountable behaviour. Professional bodies are likewise moulded to take up more of a governance role within the state apparatus.

Discourse of adult learning

The discourse of adult learning draws on the disciplinary knowledge of humanistic psychology. Why has it become important and how has it shaped approaches to learning? The basic question returns - do adult learning approaches produce a more effective professional? That this seems to be the case is shown in the literature (for example as it relates to problem-based or problem-related learning), as these approaches more effectively harness learners' motivation, help them relate the learning to their professional experience, and make it more relevant.

It is possible to see the technologies of power at play here. Mentoring and facilitation are expressions of 'surveillance' and 'examination', albeit devolved down to learners and their peers. Thus team learning and interprofessional learning permit the aim of controlling professional behaviour through the maintenance of normative standards to be actualised. Learners have internalised the control - Panopticon is alive and well.

The educational system finds this discourse fulfilling two useful roles: it is congruent with the ideology of the individual developing an autonomy of thought and action, and with the reality of responding to the exigencies of the workplace. Thus on the one hand learners have greater choice and feel more in charge of their learning; on the other the content of learning is made more relevant to the needs of the employers.

The impact of discourses on the policy process and the education structures

Policy-making and the policy implementation process can be seen in terms of an expression of societal power. I have suggested that these processes are the crystallisation of the circulation of power through the system, that they are part of the creation of new structures and behaviours. Thus the expression of governmental policies on CPD and IPE has moved from being advisory and exhortatory to having a definite legislative shape, which enables compliance to be monitored and any deviancy from the norm to be identified. This is the power of discourses. They result, albeit usually unconsciously, in the adoption by other parts of the system of the perspective of the prevalent power elite.

Why have CPD and IPE assumed such an important role in the governance of professionals? CPD has become a means of control, as the need to keep up-to-date is ever more acute with rapid changes in professional knowledge. On the other hand IPE is seen as a tool for achieving well-functioning teams and controlling the powerful professions. Such tools cannot be left unused and they have become part of the expression of the discourse of management.

Education structures have changed as well. The most notable change has been the emergence of the intermediate group, the group that is concerned with the commissioning and purchasing of education. It has taken on a much closer role in monitoring the delivery of education and also the professionals' use of it.

What role do the discourses play in this? All of them find expression in the policy documents and in the discussions of the principal stakeholders, and all of them affect the shape and function of education structures. The discourse of management foregrounds efficiency as a primary imperative for professions and their education. In addition, as the process of control requires evidence of compliance with stated (and agreed) aims and objectives, this discourse shapes acceptance of the need for surveillance and monitoring. The discourse of excellence supplies the standards and norms for professional behaviour that are acquired and maintained through professional education. These standards and norms are shaped not only by the professions but by the management group, through the rhetoric of continuous improvement of the delivery of care and responsiveness to the needs of

service users. The discourse of adult learning contributes the educational tools for changing professional behaviour. By bringing to the fore the learner's individuality, these tools provide justification for their use, even though in reality they allow the acquisition of the requisite attitudes to be more effectively controlled.

Whilst it is clear that the management discourse is in ascendancy, the interplay between the three discourses illustrates the ever-changing landscape of societal power. In Foucauldian terms there is not a simple takeover by one discourse, but rather a continuous dialogue between them, a struggle, which is characterised by the resistance within the system. This in turn shapes the discourses and their impact. Dwyer (1995), in his analysis of post-compulsory education, warns against a simplistic view of Foucault's concept of power. He suggests the policy process ought not to be seen as a top-down articulation of power, but rather as a complex, developing activity where all the actors play an active role.

9.5 INTEGRATING THE PICTURE

Is it possible to present an integrated picture that combines different perspectives on the world of CPD and IPE? What are the possible implications for the professions and their education?

I would like to suggest that it is indeed possible to have a more comprehensive understanding of the forces at play and of the actions and thinking of the key stakeholders. Even more importantly, the insights gained during this study provide the means to dissect the changes to the professional education field itself.

I believe that each view in this two-fold perspective complements the other. Thus the policy and power analysis using pluralist and hegemonic models looks at the action of the stakeholders, allocates motives and explains the direction of change. The poststructuralist analysis focusses on the hidden forces, exemplified in discourses, and on the role of societal power. The poststructuralist analysis suggests that the expression of stakeholder activity, namely policy-making and the development of new structures and procedures, is the result of discourses of power. The path of influence is not one-way - it would be naive and dangerous to suggest that human agency is at the mercy of these discourses. The actions of stakeholders and their ideologies are in part independent from the discourse of power. Consequently they are able to shape the discourses as they are an integral part of the power system, and the expression of societal power is a result of a dialogical process. While a principal driving force of societal power is to achieve an efficient

society, the exact expression and impact on stakeholders varies according to the degree of acceptance or resistance that is a corollary of the trajectory of power through the system.

How has my (which I believe to be commonly held) perception of professional education changed as a result of my work? In summary, the picture that emerges is as follows:

Professional behaviour needs to be controlled in a more effective way in the current stage of development of the welfare state. In consequence, professional education is becoming a more integral part of the governance of professionals. Economic challenges, pressures for a more effective use of resources, create drivers for change that act from both the top and bottom of the system. The top of the system is represented by the policies and actions of the government and the rest of the management group, who introduce changes partly because they perceive a need for altered priorities in the governance of the welfare state and the welfare professions. A parallel driver from the bottom of the system is more clearly evident in the discourses of power which, whilst shaping the behaviour of all actors in the system, manifest primarily in the actions and thoughts of the professionals, who 'spontaneously' try out innovations in professional education to improve the efficiency of their performance.

The impact is felt mainly at the level of teams and in professional education, namely CPD and IPE. Governmental policies are designed to embed changes into the functioning of the education system and to ensure the commitment of professionals to the objectives enunciated from the centre. However, the state is using the technologies of control, namely aspects of professional self-governance and education, emerging from the bottom of the system, that have proved effective in changing professional behaviour. Professional self-governance is harnessed by the managers to encourage professionals to take on the responsibility for continuing competence. Also, adult learning approaches are preferred as they motivate professionals to learn with an eye to the continued relevance of their learning. The end result is a loss of the predominance of professional influence both at the state and local level. The state-management hegemonic axis is in the ascendance.

Two reactions to this analysis are possible.

The one implied above is of acceptance, of observing dispassionately the changes in the configuration of different stakeholders and their influence on the shape of professional lives and education. This stance accepts unquestioningly the need for change, especially as it sees the discourses of power enabling society to achieve its primary goal - to improve the living conditions

of its citizens. In this scenario professions are just a tool for effective governance. The power and responsibility given to them can then be seen as a transitory gift to specific occupational groups, which can be removed if they do not fulfil their mandate.

The second reaction inevitably comes from a view of the professions as altruistic, holding a special remit of caring for individuals, and where the primary concern is with relieving distress and suffering. In such a view the imperative of value for money is secondary, as individuals could be seen to be sacrificed on the altar of economic probity. Whilst not denying the need to use scarce resources responsibly, a professional would argue that individual needs must come first. It would be incorrect to ascribe to the managers an uncaring attitude towards the clients of their services, but their priorities are different - the population takes precedence over individuals, and political imperatives or fashions (e.g. waiting lists) dictate their actions. The above analysis shows that the traditional position and autonomy of professions is threatened, and with it the role professions can play in defending the population from an even greater degree of control through a standardised, mechanical, 'care by numbers' approach.

I want to suggest that this analysis can serve to illuminate the action and thinking of the key stakeholders in professional education. The agenda to which I subscribe is represented by the second view, which suggests that it is necessary to resist the encroachment of monetarist ideology, the management discourse, into the professional world. This then is the agenda for the professions - to raise their members' awareness of the insidious seductiveness and consequent dangers of this discourse and actively to mould the alternative framework of thinking and action. The discourses can be managed. It is not sufficient merely to adopt the prevalent management discourse. It is, rather, necessary to highlight the discourse of excellence. In this I echo Fairclough's call (1993) for a greater awareness of the changes in societal and institutional discourses, as they mould not only thinking and values, but also the actions of individuals.

9.6 CRITIQUE

There are aspects of my work that potentially make my conclusions less safe and robust. The major areas are: source of data, bias, and the use and development of an analytical framework.

9.6.1 The source of the data

One important critique can be levelled at my work. As I did not obtain empirical data from the professionals directly, their perspective on the policy process, on CPD and IPE, is absent. However,

I need to modify this statement. Information collected during various meetings I attended as a participant observer did come in part from various professionals who were members of committees or participants in conferences. This information is not pure in the sense that I did not obtain it through interviewing them. Where I did interview professionals, this was primarily with an interest in their perspective as active actors in the educational field, such as teachers or associate advisers. Nevertheless, their personal professional experiences did inevitably colour their contributions. In addition, the absence of a 'pure' professional perspective was pragmatic as I felt that sufficiently rich material had been gathered to answer my questions.

9.6.2 Personal bias

An important bias in this work is introduced through my professional orientation. As a GP, I am inevitably most familiar with the history, development and current state of policy-making among all the key stakeholders as it relates to the medical profession. Thus, while I talk of other professions, namely nursing and social work, I am less familiar with all their specific issues. In consequence, many illustrations of various points in the literature review and in the analysis relate to the medical professions, and in most cases to general practice.

In addition, I need to point out the other aspect of this bias, resulting from my socialisation to the medical profession. My appreciation of the importance of issues in policy-making, policy implementation and interprofessional contact is frequently coloured by the medical perspective. Even though the medical profession is the dominant profession in the health service and perhaps in the whole welfare service structure, nevertheless it has to be recognised that a professional from a different background would have analysed these issues in a different way. Thus a nurse might view the diminishing power base of the medical profession more favourably, especially since nursing is coming to take a more central role in the health service. I have taken a specific stance, and made a commitment to a specific interpretation of the world I have examined. This, as Perry (1968) suggested, is valid in situations where not one but multiple views are current. Thus, I have found that one of the key findings, i.e. the decrease in professional autonomy, offers a strong explanatory framework for recent changes in the welfare state.

Despite these potential reservations I feel that I have presented a balanced picture. Further, the attack on the professions exemplified by the case of the medical profession is a warning to other professions of possible changes to their own standing.

9.6.3 The analytical framework

Three issues relating to theories underpinning the analysis deserve critical attention - their type, their selection, and their use.

Type of theories and their selection

The theories I have used fall broadly into two categories - positivist and poststructuralist. The major themes of the thesis, namely organisation of health care and professional education, the policy process, power and education, are then discussed within these two paradigms.

Criticism could be made of the types of theories I have chosen and the depth to which I have explored them. I wish to put forward the case that offering a two-fold perspective (the positivist and poststructuralist) on all the major issues provides an opportunity to see some of the strengths and weaknesses of each paradigmatic theory formulation. The theories I have chosen are mainstream, and used legitimately in other educational contexts. Consequently I felt justified in selecting them and their value was shown repeatedly during the analytical process, when a consistent picture began to emerge under each theoretical formulation. In addition, it was useful to see when different paradigms agreed and, contrariwise, when they presented contrasting interpretations.

Use of theories

How legitimate was my intent to analyse the data from apparently contradictory epistemological stances? Thus, for example, selection of the theories pertaining to power could be criticised for the choice of two such opposing views - from the positivist paradigm the pluralist and hegemonic, and from the poststructuralist the Foucauldian view. Other, just as relevant, theories (e.g. Lukes (1974)) or more complex frameworks (e.g. Clegg (1989)) were thus left out. However, I have taken a route that is congruent with the two strands of the analytical tradition of policy-making identified by Whitty and Edwards (1994). Here, the first conceptualises it as an interplay between power groups and the second sees it in terms of discourse positioning. The difference is that I am producing a composite picture. This has been my approach throughout the analysis - to offer a much richer picture composed of a confluence of different perspectives. I do not wish to suggest that either represents reality, only a different view of it.

Further justification for combining multiple theoretical perspectives comes from at least two positions. The first, drawing on Denzin's (1970) exploration of triangulation, admits of different theoretical conceptualisations to arrive at a composite picture that might offer a more complete

understanding of the phenomena under study. The second position ensues from postmodernism. Within this framework the researcher ought to strive to seek different views, on the basis that no single one of these will approximate the elusive truth. Further, enrichment of perceptions could provide an opportunity for silent or silenced voices to be recognised, voices that the prevalent, hegemonic discourse might suppress. Leicester (2001) in his thoughtful analysis of the tension between the modernist and postmodernist projects coins the term 'post-postmodernism'. In essence he argues that extremism of each project is counterproductive and that it is more useful to embrace both the rational and relational views of the world, as they can successfully complement each other. His analysis is particularly apposite for my work as he focusses on life-long learning, where these two positions collide: both a need for progress and the blurring of traditional boundaries between the spheres of life and academic knowledge.

9.7 EVALUATING THE RESULTS - HOW VALID ARE THESE CONCLUSIONS?

The analysis presented here appears to be grounded in a lived-in reality of the subjects and the actions of the stakeholders which provided a source of data for this research. Of course, it is possible that a different researcher, using different methods or theoretical frameworks, could have come to different conclusions.

Two options appear to be available for confirming the results in the future. The first would involve verifying with a wider group of professionals and managers whether this view of reality resonates with their perceptions. This could be achieved in a number of ways: through presentations, discussions or publications.

The second option would involve further collection of data, perhaps in the form of questionnaires, to test out the key conclusions.

Nevertheless, the changes in professional governance and education that I have identified, namely the gradual disempowerment of the professionals in the caring field, are real. This process is evident in continued pressure from the government for increased control. This takes various forms, such as a regular checking of competence that is outside self-regulation, or the introduction of more comprehensive surveillance mechanisms of performance.

What have I learned?

As work on the thesis progressed and as my analysis uncovered these trends towards professional disempowerment, the element of despair that I as a practising professional have felt for some time deepened. It additionally seemed that these trends were irreversible, as a multitude of forces were conspiring towards them. It was especially the concept of the discourses of power, with the implied elemental nature of these forces permeating society and the thinking and action of its individuals, that seemed to show the inevitability of changes.

However, I now carry a somewhat modified picture. Resistance is possible. An improved awareness of the discomfort caused by the clash between the discourses, especially between the discourses of management and excellence, provides an opportunity for professionals to become more active shapers of the discourses of power.

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APPENDICES

1 APPENDIX ONE - TEAMWORK - ADDITIONAL BACKGROUND

1.1 BACKGROUND ISSUES

How did the teams, as an expression of organised co-operation between different professionals, began? What is the extent of teamwork in primary care?

1.1.1 Origins of teamwork

Teamwork in health care is not a new concept. It goes back many centuries. Pietroni (1994) has described the emergence of teamwork in the monastic infirmaries in the Middle Ages. The need to cope efficiently with a large number of wounded led to the emergence of military surgical teams of the nineteenth century. These teams bore a resemblance to the military structure, that indeed may have been necessary for emergencies.

In the UK the first well documented example of teamwork in primary care was the Peckham Experiment established in East London in 1926 (Lewis & Brookes, 1983). It advocated, for that time, a revolutionary approach to health, that was holistic with a considerable emphasis on prevention.

The advent of the NHS in 1948 provided an opportunity for the establishment of interprofessional teamwork. The trend towards closer co-operation of primary health care professionals i.e. general practitioners, health visitors, district nurses and practice nurses as well as social workers, community psychiatric nurses and physiotherapists has increased over the last 30 years (Reedy, 1981; Hasler, 1992).

1.1.2 The reality of teamworking in primary care

An interest in teamwork is evident, but how is it translated into reality? Research in child protection and primary care shows a sobering picture. Child protection has been at the centre of concern of the professional bodies and the government for a number of years, yet a review of the literature (Hallett & Birchall, 1992) showed how difficult it was to achieve the co-ordination of the services. Primary care teams have grown in size especially since the 1990 NHS reforms. As Usherwood (1997) documented this was mainly due to a need for fundholding practices to cope with additional tasks, which necessitated employment of more practice nurses, managers and other support staff. The decline in the numbers of the attached staff, namely midwives, counsellors and

community psychiatric nurses counterbalanced the development of more community orientated teams.

Perceptions by team members also question the ideal. Armitage developed a five point scale (see Table AP 1.4) for an assessment of collaboration for primary care teams (Armitage, 1983). When pairs of professionals (district nurses and GPs, and health visitors and GPs) were questioned, collaboration as assessed by the last two points on this scale, was reported only by 27 percent and 11 percent of pairs respectively (Gregson, Cartlidge & Bond, 1991).

1.2 STRUCTURAL ASPECTS OF TEAMWORK

Two issues are explored here - group roles in teams and leadership.

1.2.1 Group roles

In any team these roles emerge. An insight into their existence and their impact on the teams functioning would allow teams to understand what processes are helpful and which hinder team effectiveness. Roles that a team member takes can be one of two kind: task-orientated or maintenance role. The categories used here follow Barker's classification (1987)²⁰. These roles develop naturally in group settings such as team meetings.

- | | |
|----|--|
| 1. | information or opinion giver, |
| 2. | information or opinion seeker, |
| 3. | expediter (person who will return the group to its task, if it strays away from it), |
| 4. | ideas person, |
| 5. | analyser. |

Task-orientated roles are five-fold (see Table AP 1.1 - Task-orientated roles Table AP 1.1).

Maintenance roles will enable the team to focus on its tasks, provided that sufficient attention is paid to group processes and emotional interaction. Barker (1987) identified five roles (see Table AP 1.2).

²⁰ An alternative classification has been produced by writers such as Belbin (1981). The roles identified by him are: Co-ordinator, shaper (task orientated), implementer, team-worker, plant (ideas person), resource investigator (trading and co-ordinating ideas), monitor-evaluator, completer-finisher and specialist.

Individual members will adopt roles according to need - one person can have different roles at different times. However, a member with a specific personality profile will tend to adopt the same role repeatedly. Thus an individual with an inclination towards reflection is more likely to be the analyser or active listener, while the more action orientated member might be the expeditor.

- | | |
|----|--|
| 1. | active listener, |
| 2. | game leader (person able to bring in light relief if group is stuck), |
| 3. | harmoniser or compromiser (able to diffuse tension and reconcile differences), |
| 4. | gatekeeper or facilitator of group process, |
| 5. | the front person (functioning on the boundary of the group) |

Table AP 1.2 - Maintenance-orientated roles

A range of negative, self-serving roles can be played out in a group that can hinder its effective functioning. There are six of these (see Table AP 1.3). For a group to deal constructively with these negative behaviours, it needs to be sufficiently aware of group processes or it needs a facilitator capable of pointing out the enactment of these roles.

- | | |
|----|--|
| 1. | aggressor, |
| 2. | blocker of ideas of others, |
| 3. | competer for attention, |
| 4. | joker (as distinct from game leader, joker's behaviour distracts), |
| 5. | withdrawer, |
| 6. | monopoliser |

Table AP 1.3 - Negative group roles

1.2.2 Leadership in primary care teams

Leadership as a role

Øvretveit's (1987) description of the team leader's role in different teams centres on two functions: the management of team members to complete a task and the inter-personal support of team members. This is consonant with the two main categories of team roles outlined above - the task roles and group maintenance roles. The team leaders' task is to co-ordinate these roles. Leader, in addition, needs to be concerned with the needs and development of the individuals.

The task functions can be seen to correspond, for example, to stages of a project undertaken by the team - planning, initiation, control, review and evaluation.

The leadership supportive functions during the work of the team will include openness to contact from team members and accepting individual contributions, as well as fostering growth, and maintaining team spirit. Not all of these functions need to be exercised by the formal leader. Some of these can be delegated to team members or they themselves may spontaneously take a lead for a stage of a project. However, the responsibility for co-ordination rests with the team leader.

Leadership of the primary care team.

The reality of leadership in a primary care team is complex. Its form and relationship between the leader and the team members are determined by a number of factors. Modifying conditions include the degree of integration of a team, the extent and complexity of a team, tasks of a team and team processes.

The type and presence of leadership is linked with the degree of integration in the team. The fully integrated team may not require an appointed or agreed leader as most of the leadership functions are shared, while in the less integrated case a leader is needed and competition for the leadership position may arise.

The professional's role as a leader of the primary care team can take several forms - leader of a team of equals, (which occurs more frequently in uni-professional team), or leader of an interprofessional team. For the latter differences in power, status and responsibility need to be acknowledged, or if this does not happen substantial conflicts will surface and co-operative effort will be sabotaged. Frequently it is assumed (mainly by doctors) (Greig, 1988) that doctors are natural leaders of clinical teams as, arguably, they need to retain responsibility for continuity of care. However, it is the power and status associated with medical members of the team that frequently puts them into a leadership position in an interprofessional team (Poulton, 1977). Tensions can arise in this context if the leader's position is due to associated power and status and not because the person is the best qualified for this role. The members of the team may not accord respect and may not co-operate willingly on common tasks.

The remit of leadership depends on the degree of need for co-ordinated action. Independent functioning characterises professional work. Professionals do not necessarily feel the need to be led.

A number of scenarios in primary care needs to be explored in order to gain a clearer picture. GP partnerships will have a lead partner, usually the most senior person. Nowadays, most GP practices will have appointed practice managers. Baker & Willmer (1995) remind us that a role of manager in primary care teams has developed in recent years. Even though they, with rare exceptions, are

employees of the GP partners, they have been taking on an increasingly important remit in the development of primary care, moving from operational to strategic management and leadership. Nevertheless, the authors locate the management role in the individual, and this can be the manager or the professional, or the team itself.

Clinical collaboration between GPs and other professionals requires some degree of leadership. In most cases the participative style is best suited for such situations, for as noted, professionals do value working autonomously. To achieve an effective co-ordination of work, the leader needs to gain respect, otherwise team members may not feel committed to the team's aims. Not all the tasks of the team demand co-operation, thus leader's role is delineated by those tasks that benefit from clarifying the division of labour and pooling of resources to achieve a desired end. The best example are the functional teams, where a specific, time or remit limited task demand such a co-ordination of professionals' effort.

What is the research evidence linking leadership arrangements and the team's function? In the health and social care field evidence is scant. Vanclay (1996) did relate management support and quality of leadership to collaboration in primary care teams. Outside the welfare field evidence is stronger (Pinto & Prescott, 1987; Larson & LaFasto, 1989; Sundstrom, De Meuse & Futrell, 1990).

1.3 TEAM FUNCTIONING

Two aspects of team function are explored here, namely some elements of collaboration and a team culture.

1.3.1 Collaboration

Classification of collaboration

It is possible to classify a degree of collaborative working from absence to a total integration of skills, task allocation and use of financial and other resources. Armitage (1983) was one of the first to offer a taxonomy of collaboration (see Table AP 1.4). Studies of teamwork (Bond et al., 1987; Koppel & Morris, 1993) using this framework show that collaboration is dependent on structural and functional proximity.

Research evidence on collaboration in primary health care teams

The relationship between collaboration in primary care teams and diverse features in the context, structure and function of the teams has been explored in a number of studies.

Gregson et al (1991) in their review showed that an important focus in primary care research studies has been on the perception of the professionals involved, what they see as the **advantages and disadvantages of attachment**. These included:

- aspects of interprofessional interaction such as communication,
- satisfaction with the working arrangements,
- understanding of the roles and competencies,
- linked issues of respect for autonomy, status and professionalism.

1.	Isolation	We never meet, talk or write to one another
2.	Encounter	We encounter or correspond together but do not interact meaningfully
3.	Communication	Our encounters or correspondence include the transference of information
4.	Collaboration between two individuals	We act on that information sympathetically, participate in patterns of joint working, subscribe to the same objectives in the same organisation
5.	Collaboration throughout an organisation	In our organisation the work of all members is fully integrated

Table AP 1.4 Collaboration scale

Positive findings such as improved understanding of the roles and better decision making (Corney 1980) was linked with attachment schemes or joint clinics (Field, Draper & Thomas, 1984). Glendinning et al (1998) in their review of the attachment of social workers or care managers to general practices noted a number of positive outcomes. The studies reported improved communication and mutual understanding especially if associated with joint training. Better communication resulted in an improvements in process outcomes in these situations - quicker

referrals, better feedback and less inappropriate referrals occurred. Authors remarked that so far the studies failed to show firm evidence of a direct benefit to patients.

However, more studies report problems with appreciating the role and competencies mainly of community staff by GPs, or HVs by other community staff, even against the background of overall satisfaction with collaborative arrangements (Gilmore, Bruce & Hunt, 1974; Poulton, 1977; Draper et al., 1984; Wiles, 1994).

Another factor that influenced collaboration was **the size** of the GP practice - larger practices referred more elderly patients to PNs and DNs (Strang, Caine & Acheson, 1983). A comprehensive study of primary care professional pairs (GPs and DNs, GPs and HVs) produced similar results (Gregson, Cartlidge, & Bond 1991): increased collaboration existed under conditions of geographical and temporal proximity, with good mechanisms for exchange of information, and where friendly relationships and doctors' understanding of other professionals' roles existed. Practice nurses have positive experiences of working in good teams and feeling understood by the GPs (Thomas & Corney, 1993) - this is clearly related to proximity working.

A number of other studies have emphasised that focussing on an **agreed task** facilitates team function (Spencer et al., 1993). Recent study (Vancly, 1996) focussing on collaboration between social workers and GPs found three interdependent factors sustaining the co-operation. These were:

- different formats of shared education and development, including having protected time and adequate resources for such initiatives,
- appropriate structure and organisation, including management support for teamworking and attachment schemes of SWs to practices,
- sharing of information, including understanding and knowledge of each others roles and respective organisational structures.

1.3.2 Team culture

Traditionally culture meant (Morgan, 1997), (p120): '...a society's system of knowledge, ideology, values, laws and day-to-day ritual.'

How does this contribute to our understanding of the work and function of interprofessional teams? Morgan (1997) suggested that corporate culture can be a powerful determinant of an organisation's success in dealing with the challenges of a changing world. One hears frequently of conflicts

arising due to incompatibility between cultures of different groups, organisations or a professions. A potential for failure in a teams' effort is real if such incompatibilities are difficult to overcome.

There are a number of perspectives on culture as a concept, both in sociology and organisational theory. The two major schools of thought in sociology, structuralist (Clarke et al., 1992) and functionalist (Hall, 1992) emphasise different aspect of the phenomenon. The structuralist would focus on patterns of codified behaviour, that would find an expression in (Clarke et al., 1992) (p53): 'patterns of social organisation and relationship through which the individual becomes a 'social individual'.' For instance, a new partner in general practice will need to uncover the structure of the relationship between different groups, who holds the power and how the ability to influence decisions is distributed in the team. Is it the senior partner or the manager who is the force behind new developments? Are practice meetings dominated by GPs or do the other professionals have an opportunity to contribute constructively to a debate?

The functionalist would concentrate on the function the culture carries in a social life, namely to promote an adaptation to a given role, a group or a social setting through the transmission of a systematised collection of values, meanings and norms. An observer might want to note the pervasive values developed in a specific practice. Is the practice subscribing to an altruistic set of values to provide a high standard of care through investment in additional equipment, even if it means lowering the income? Is there a true commitment to life-long learning manifest in ensuring a provision of protected time to all its members?

In organisational theory a more inclusive perspective is taken. The following characteristics reflect organizational culture (Luthans, 1989), (p50):

- observed behavioural regularities such as language and rituals,
- norms of behaviour,
- dominant values,
- philosophy or mission,
- rules,
- organizational climate.

The dominant culture as a concept refers to perceptions shared by all members of the organization, while subcultures appear in smaller subdivisions - teams, departments, professional groupings or ad-hoc interest groups. Cultural subdivision may also occur along social or ethnic lines. A potential for conflict appears if the subcultures clash, even though there may be a substantive commitment

to the overarching set of values. Coles and Perides (1995) documented such a clash between the professional and managerial subcultures in the organisation. Difficulties in reconciling their respective set of values prevented collaboration and agreement on change.

The strength of a group culture is determined by the degree to which its components are shared. The intensity of commitment to shared values can be influenced by a process of initial orientation to the group and is reinforced by rewards and revisiting the meanings inherent in a group's mission. Allocation of rewards, be they material or affective, would need to be egalitarian within a team to prevent resentment building up and a loss of commitment by individuals to common goal. The key ingredients in the creation of a corporate culture are its history and leadership.

Professional tribalism

It is possible to see the socialisation process of the novice into professional norms, beliefs and ethics as a form of joining the tribe by acquiring and later subscribing to the culture of the profession. Beattie (1995) noted the increasing popularity in academic circles and in the NHS of describing the tensions arising between professional and other occupational groups in terms of tribalism. The origin of differences include the historical development of professions, their differential status, and maintenance of this differential through the control of education and self-regulation. What happens when different professions get together in teams and common culture of the team or organization conflicts with professional culture? It can be argued that successful teams are able to break down these interprofessional barriers if the individuals feel able to subscribe to a common set of beliefs and assumptions.

The culture's rules and norms are not static givens, they represent a continuous recreation of shared meanings through communication, symbolic expressions (e.g. mission statements), and ritualised behaviour such as meetings. The culture of the organization is maintained through the selection process, initiation, job mastery and reinforcement procedures, including rewards.

Changes in organisational culture can be equated to paradigm shifts, with changes in the prevailing set of assumptions, perspectives and views of reality. An adaptive team capable of evolving features of its culture such as the norms and values will qualify as a learning organisation (see further reference in Chapter Four).

A word of caution, though. The culture of the team can have a negative impact on the functioning of its members. It can exert a coercive influence on the behaviour of the professionals as the need

to maintain group norms and rituals can override individual or professional freedom (see also Chapter Three).

1.4 THE OUTCOME OF TEAMWORK IN THE HEALTH SERVICE

Two main groups of outcomes for teamwork are - those relating to the process of care, such as the use of services, compliance with management guidelines, referral patterns and admissions to hospitals; and those reflecting the direct impact on patients, that range from the social and emotional indices to physical outcomes, including survival rates.

Most studies look at the relationship between the structured organisation of care and outcomes, while few correlate the quality of collaboration and the outcomes. The majority of the studies mentioned here use robust methodology, such as randomised controlled trials or other forms of comparative research. Evidence thus offered could provide a more reliable level of proof about the impact of teamwork on patient care.

A number of studies compared a structured, multi-disciplinary approach to care in various conditions with unstructured, traditional care. On the whole evidence points to positive patient outcomes as measured by changes in physical or social function or use of services.

1.4.1 Teamwork effectiveness in primary or community care

A longitudinal study of hypertensive patients documented changes to their care as a result of moving from doctor only format to doctor-nurse team approach (Silverberg et al., 1983). Results showed the control of hypertension increased from 42.1 percent to 84.6 percent with the Dr-nurse team. The other aspects of the process of care improved too - waiting time for patients was less, overall there were less visits to doctors, and the dropout from follow-up diminished from 30 percent to 1 percent.

A meta-analysis of comprehensive geriatric assessment (Stuck et al., 1993) showed a varied impact on patient indices. If three formats relevant to primary care are considered - geriatric evaluation and management units, hospital to home assessment service and home assessment service, analysis showed that such a service helped to retain patients at home longer by avoiding their admission to an institution. Figures also showed a decrease in mortality and in the risk of hospital re-admissions. Cognitive function improved as well.

Case management within a team framework is another model of interprofessional co-operation. Two studies comparing intervention groups with control groups in the community showed the effect of structured team care on patient outcomes. The first study designed to support the frail elderly in the community involved a case management team comprising a social worker, a nurse, a doctor and a physiotherapist (Challis et al., 1990). In comparison with the matched cases, the elderly in the project group showed a significant improvement as a higher proportion stayed at home rather than entered institutions at the end of one year.

In the second study (Challis et al., 1991) the results were also significant: a higher proportion of the elderly in the intervention group stayed in their own home and their morale was better, and depression and apathy improved. Their need for additional care diminished and their social activity was higher. The impact on carers was significant too: they felt better, less stressed and the proportion of tasks they had to perform decreased significantly.

Establishing a primary care team approach in an urban deprived area changed the behaviour of the multiproblem families from consulting GPs for illness related issues to a more proactive, wide ranging use of the team (Beloff & Korper, 1972). The families in the study began to see the GPs less often and sought guidance on, for example, counselling, marriage guidance, employment issues and health education.

1.4.2 Teamwork in a hospital setting

A review by Halstead (1975) identified 10 studies published prior to 1975 comparing the effect of co-ordinated teamwork on health outcomes, with standard care. Six were controlled studies, others matched the subjects, and all dealt with chronic conditions. Most studies showed positive changes on some of the indices (social, intellectual function, mobility, morbidity or mortality, use of services or other costs). Thus five studies demonstrated improvement in functional status, in another five there was no change or it was equivocal; four out of ten showed decreased morbidity with no change, or equivocal results in others.

In other conditions a mixed picture emerges:

- positive health outcomes, including a lower use of health services, in paediatrics (Alpert et al., 1968),
- improvements in care of pregnant adolescents (Smoke & Grace, 1988),

- a better performance on a number of indicators, including savings in costs, in early stages in renal failure (Levin et al., 1997),
- equivocal results in stroke (Wood-Dauphinee et al., 1984),
- contradictory results for a team care in rheumatoid arthritis. An improvement was reported in two studies - in perception of health and mental health functioning (Ahlmen, Sullivan & Bjelle, 1988) or better functional outcome (Katz et al., 1968).

1.4.3 Quality of collaboration and team effectiveness

A randomised study by Feiger and Schmitt (1979) showed that teams with a higher degree of collegiality (equal participation in discussions and decision making) had greater positive impact on the patients' health status (this covered social, physical and emotional function). Three studies of intensive care units correlating collaboration (and other indices of team function) and mortality produced equivocal results (Knaus et al., 1986; Baggs et al., 1992; Zimmerman et al., 1993).

1.4.4 Evaluation of research evidence on teamwork effectiveness

What conclusions can be drawn from these studies on teamwork?

If one looks for an evidence-based approach to organisational change, the guidance offered by the experimental studies in the health service is mixed. The research in primary care appears to have produced positive results, while secondary care outcomes are equivocal. Is there a publication bias for primary care studies? Clearly, it is difficult to accept that teams in primary care are invariably effective. Evaluation of the impact of team care in a health care setting is not easy. The problems researchers face were reviewed by Schmitt et al (1988). Difficulties were due to:

- lack of design of rigorous methodology (different settings of care, small numbers of patients or teams),
- team care as an independent construct being a complex variable (differing types of team, degree of collaboration and expertise within team),
- outcome of care being multidimensional,
- assumption that all kinds of patients would benefit from team care.

An additional observation about primary care research was made by West & Slater (1996). They noted a lack of robust indicators of effectiveness of primary care services. The diffuse nature of

primary care, the presence of relatively few identifiable and reliable end-points of the care process, underlies the difficulties in measuring the outcomes.

Nevertheless, considering the studies cited in this chapter, it is possible to conclude that there is a reasonably valid evidence of the link between aspects of teamwork and the outcomes.

2 APPENDIX TWO - SUPPLEMENTARY TABLES FOR CHAPTER FOUR

ISSUES	LEARNING OUTCOMES
Team member issues	
professional insecurity related to the extent of responsibility and associated doubt about having appropriate range of skills	re-affirm confidence in own profession's contribution to team effort and be able to clarify in the team the boundaries of responsibility
differences in educational preparation	identify situations of potential conflict arising from different educational background and plan further learning according to identified need
conflicting views of roles of other professions	clarify and agree on a common perspective on professional roles, learn to respect contribution of others
limited or different view of patient care and needs	identify underlying care ideology and learn to negotiate agreed patient care plan
use of professional jargon	learn to avoid use of professional jargon or improve understanding of underlying conceptual frameworks
differing or conflicting ideologies and values	clarify the conflicts arising in different professional ideologies and values and understand their origin
status differentials, problems of legitimate authority and differences in power	learn to overcome stereotypes in behaviour and to challenge interprofessional prejudices
gender differences : inequality of power and opportunity to influence decision making	become sensitive to manifestation of gender differences and address underlying prejudices and inequalities
Team function issues	
a climate for collaboration	learn to acknowledge the need for interdependence
tasks need to be co-ordinated by interprofessional liaison	improve liaison skills
Team function issues	
avoidance of different policies being followed by different professionals	learn to agree on common policies and gain confidence to influence change of policy-making in own professional or management structure
lack of united service philosophy	learn to merge professional interests by putting users at the centre of care

ISSUES	LEARNING OUTCOMES
need to maintain team's integrity	develop commitment to team 's viability and improve skills for interprofessional interaction
negative attitudes to each other	identify negative attitudes in self and others and learn ways of overcoming them
incompatible views and attitudes on teamwork cohesiveness	learn to negotiate and tolerate diversity

Table AP 2.1 IPE and interprofessional issues

FACTORS		promoting	inhibiting
Individual - background issues	attitudes to IPE	-	(England, 1980; Jones, 1986)
	knowledge, skill differential	-	(England, 1980; Loxley, 1980; Jones, 1986; Stanford & Yelloly, 1994; Carpenter & Hewstone, 1996)
	intellectual capacity differential	-	(Loxley, 1980)
	lack of motive - no assessment	-	(Lucas, 1990)
	different stage in training	-	(Loxley, 1980; Jones 1986)
Individual - as a professional	culture	-	(Beattie, 1995)
	professional values	-	(Maggs & Purr, 1989; Pomeroy & Philp, 1994)
	professional perspective, boundaries	-	(England, 1980; Lucas, 1990; Stanford & Yelloly, 1994)
	previous education/ professionalisation	-	(Maggs & Purr, 1989)

Table AP 2.2 Individual issues affecting IPE adoption

FACTORS	promoting	inhibiting
Learning needs analysis	(Lucas, 1990)	(WHO, 1988; European Health Committee, 1993)
EDUCATIONAL PHILOSOPHY ISSUES		
difference in educational philosophies	(Shakespeare, 1997)	(Stanford & Yelloly, 1994; Shakespeare, 1997)

FACTORS	promoting	inhibiting
adult learning approach	(Loxley, 1980; Funnell, Gill, & Ling, 1992; Stanford & Yelloly, 1994; Carpenter & Hewstone, 1996)	-
PLANNING AND ORGANISATIONAL ISSUES		
time	(Stanford & Yelloly, 1994)	(Loxley, 1980; England, 1980; McMichael, Molleson & Gilloran, 1984)
funding - inadequate or different funding streams	(Satin, 1987)	(Satin, 1987)
complexity of planning process, integration	-	(Payne, 1976; Stanford & Yelloly, 1994; Shakespeare, 1997)
planning - shared objectives & values - link to work-place needs (i.e. need for teamwork)	(Brown, 1993a; Stanford & Yelloly, 1994; Bartholomew, Davis & Weinstein, 1996)	(Payne, 1976; Funnell, Gill & Ling, 1992; Bartholomew, Davis & Weinstein, 1996)
structure, management of course, control of content	(Loxley, 1980; Stanford & Yelloly, 1994)	(Lucas, 1990; Funnell, Gill & Ling, 1992; Gill & Ling, 1995)
size of group	(Loxley, 1980)	(Gill & Ling, 1995)
balance of professions	-	(Newman, 1978; Funnell, Gill & Loxley, 1980; Ling, 1992)
STAFF ISSUES		
attitude of teaching staff - to IPE, to students and teachers of other professions	(Loxley, 1980; Satin, 1987; Brown, 1993a)	(McMichael, Molleson & Gilloran, 1984; Jones, 1986; Satin, 1987; WHO, 1988; Brown, 1993a; Carpenter & Hewstone, 1996)
experienced interprofessional staff	(Shepard, Yeo & McGann, 1985; Thompson et al., 1988)	(WHO, 1988)

Table AP 2.3: Curriculum issues in IPE influencing its success

FACTORS	promoting	inhibiting
PROBLEM IDENTIFICATION		
standard setting and monitoring	-	(WHO, 1988)
relevance to organisational need	(Brown, 1993a)	(Bartholomew, Davis & Weinstein, 1996)
ORGANISATIONAL RESOURCES		
size and communication systems	(WHO, 1988)	(WHO, 1988)
time and resources identified	(Stanford & Yelloly, 1994; Bartholomew, Davis & Weinstein, 1996)	(England, 1980; Jones, 1986; Spencer, Pearson, James & Southern, 1993; Brown, 1994; Stanford & Yelloly, 1994)
team meetings, autonomy	(WHO, 1988)	(WHO, 1988)
differences between organisations - in culture, internal procedures		(Brown, 1994)
INTERNAL PROCESSES		
policy and its execution	(WHO, 1988)	(WHO, 1988)
INTERNAL CONTEXT		
culture (of support), managers' attitudes to IPE and/or teamwork	(Stanford & Yelloly, 1994; Bartholomew, Davis & Weinstein, 1996)	(Jones, 1986; Bines, 1992; Brown, 1994; Shaw, 1994)
relationships with colleagues (team and hierarchy) and managers	(Brown, 1993a)	(Brown, 1993a)
EXTERNAL CONTEXT		
supporting and communication networks	(WHO, 1988)	(Spencer, Pearson, James & Southern, 1993)
collaboration between agencies	(Brown, 1993a)	(Brown, 1993a; European Health Committee, 1993)
access	(Payne, 1976)	

Table AP 2.4: Work-place organisation factors and IPE

		Experimental controlled	Other experimental	Post-event
Knowledge	+ve		(Hewstone et al., 1994) - for SWs only; (Carpenter, 1995 a) - more for nurses than Drs; (McMichael & Gilloran, 1984; Carpenter & Hewstone, 1996) - differential change; (Dienst & Byl, 1981; Croen, Hamerman & Goetzel, 1984) - for Drs only; (Hasler & Klinger, 1976; Bassoff, 1983; Poulton, 1995)	(Chesney & Chesney, 1981; Lynch, 1984; Pomeroy & Philp, 1994; Richardson & Edwards, 1997) - differential; (Beynon et al., 1978; Brooks, Hendy, & Parsonage, 1981; Lucas, 1990; Itano et al., 1991; Howkins & Allison, 1997; Hughes & Lucas, 1997)
	neutral		(Croen, Hamerman & Goetzel, 1984) - for nurses only; (Hewstone, Carpenter, Franklyn-Stokes & Routh, 1994) - for Drs only; (Hasler & Klinger, 1976)	
	-ve			
Attitudes	+ve	(Mazur, Beeston & Yerza, 1979; Brown, 1993b; Shaw, 1994)	(Bassoff, 1983; McMichael & Gilloran, 1984; Bergman-Larson et al., 1985; Bolden & Lewis, 1990; Carpenter, 1995 a, 1995 b; Poulton, 1995; Carpenter & Hewstone, 1996)	(Brooks, Hendy, & Parsonage, 1981; Chesney & Chesney, 1981; Spratley, 1989; Itano, Williams et al., 1991; Hughes & Lucas, 1997)
	neutral	(Tanner, 1972; Mazur, Beeston & Yerza, 1979; Shaw 1994)	(Dienst & Byl, 1981; Bergman-Larson, Foldevi et al., 1985) - for nurses;	(McMichael & Gilloran , 1984)
	-ve	(Weiss, 1985)		
Skills	+ve		(Dienst & Byl, 1981; Ashton, 1992; Nash & Hoy, 1993 Poulton, 1995)	(Spratley, 1990; Itano, Williams et al., 1991; Gill & Ling, 1995; Howkins & Allison, 1997; Hughes & Lucas, 1997)
	neutral			(Gill & Ling, 1995)
	-ve			

		Experimental controlled	Other experimental	Post-event
Behaviour	+ve	(Mazur, Beeston & Yerza, 1979; Brown, 1993b)	(Dienst & Byl, 1981; Bassoff, 1983; Harbaugh, Casto & Burgess-Ellison, 1987; Kimelblatt et al., 1988; Brown & Adkins, 1989; Flavin & White, 1989; Walsh et al., 1995)	(Bolden & Lewis, 1990; Spratley, 1990; Itano, Williams et al., 1991; Claytor, 1996; Hughes & Lucas, 1997)
	neutral		(Flavin & White, 1989; Ashton, 1992)	
	-ve		(Spencer et al., 1993)	
Patient outcomes	+ve	(Thomas, 1994)	(Adorian et al., 1990; Skovholt et al., 1994; Thomas, 1994; Frommater et al., 1995; Joiner, Salisbury & Bollin, 1996; Schwartz, 1996)	(Tanner, 1972; Dienst & Byl, 1981; Itano, Williams et al., 1991)
	neutral	(Falconer et al., 1993)		
	-ve			
Organi- sational change	+ve		(Flavin & White, 1989; Spencer et al., 1993; Hutt, 1994; Skovholt, Lia-Hoagberg & al., 1994; Walsh et al., 1995)	(Spratley, 1989; Ferrell et al., 1995; Claytor, 1996; Claytor, 1997)
	neutral	(Brown, 1993b; Shaw, 1994)	(Flavin & White, 1989)	(Claytor, 1997)
	-ve			

Table AP 2.5 Effectiveness of IPE - summary

3 APPENDIX THREE - AN EXAMPLE OF FIELD NOTES

Working of the Education and Training Group at Health Authority on 18 September 1995.

My purpose was to observe level of knowledge and understanding of the content and substance of educational training present in this group; to gain an understanding of process of construction of its own role, roles of educational purchasers that is different to this health agency group, and function of educators. Also wishing to observe processing of the information from above and needs and influences from below. The key issue is how they have developed the need for such a role, the extent of the power and influence of this committee.

Report and initiatives Dr A believes NHSE did not particularly understand a couple of submissions (quality of information or understanding or rather lack of understanding of frame of reference on either side appears to differ). Not approved primary care team development post which was in any case intended to save money from central budget. *(Struggle for power, trying out the boundaries.)* Support for an interest for helping GPs who are failing or those not fully employed, being locum, and might need an intensive education input for "re-entry". Suggestions from Leeds that some of these formats or initiatives could be channelled through academic units as there is no legal framework for these to be done directly through LIZ was not accepted by the group as academic units would be just used to circumvent the poor legislation. *(Also the personal perspective via Dr A)*

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NB suggests that those recent VTS graduates could be employed but it was not approved by Leeds, directly by agency but it would mean dipping into management funds. *(Note the openness to innovative ideas and ability to overcome from the top the potential obstacles.)*

The controlling or rather steering mechanism for the LIZ initiative is being put in place *(innovation, slow process)*. The coordinator should be appointed at the end of October. The site is located at the regional office at Trust A but needs to maintain link with FHSA and primary centre, even if eventually it will be at the primary centre, there is a need for loyalty to be maintain *(power, influence)*.

Setting up consortia

Current local hospital-based consortia in health authority area a real shift and a real match with the boundaries by incorporating the guidance. From EL (95) 86 discussion picked up among others the key role of consortia in monitoring of quality education provision, in the first place an appointed monitoring officer. Note comment from Ms B that not all education providers are delivering high quality *(process of quality control, i.e. power in education purchasing is being dissolved)*. Future consortia will include health agency reps *(thus role of health agency in direct influence on education will increase. At the moment it appears to be mainly a discussion, reporting, learning group.)*

61113
62221
6424

Manpower planning as yet is quite undeveloped on all levels so there is a need for investment in specific areas - educational provision is unclear.

EL (95) 96

Interesting to note the group's acceptance of critical views from Ms C that this particular guidance (from NHSE) might be somewhat one-sided and not providing an evidence-

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6121

based approach. The basic motive behind this criticism is clearly an implication that health commissioners will need to provide more funds for the extra staff which might be identified as a need from below, i.e. from GPs, social services for staff like psychologists, OTs and physios. *(Reacting and trying to modify the influence from above.)* Answer is to respond to those guidelines by writing to Region about its concerns including inadequate mention of skill-mix, even if there is some reference to NVQs. *(For the process of trying to influence the top through bouncing back by making them feel that they have not defined the problem adequately.)*

Dr D notes repeatedly that there is a need to look what is the genuine educational need and demand, which should be the R&D task of the primary centre education centre, but he is questioning whether there is the money to invest in such an initiative. The answer appears to be possibly as a developmental initiative. *(Process of negotiating of delineating power of new education provider to take on an informed role where information equals power.)* Note the pressure to investigate the skill need and the associated need and demand for education and also suggestions that one needs to look at what are the obstacles to the deployment of staff. *(Formulating the function of the group the processes of shaping the change. Suggestion that strategic approach is appropriate but also making it more impersonal, mechanistic.)*

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The role of GPs in education (Dr A)

Note comment that education has a long lead time; one cannot expect immediate skill application from training provision. Looking at GPs, it's very difficult to plan their development as they are independent professionals who need incentives. Dr A is expressing some frustration that GPs do not themselves feel a necessity to change. *(Note the position she is taking, i.e. someone on the management side who is frustrated with lack of real power and influence, but also note Ms G's comment in other setting that GPs and doctors in general are good learners and are responsible.)* Other frustrations from Mr J that GPs as employers do not release staff, they perceive their needs to be more short-term related to their practice. Some discussion about what incentives or sticks and carrots could be used. *(Identifying means of influence.)* Ideas coming out from the group are like investment in people, service-based learning, action learning.

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9211

Dr A mentioned that the problems are of course the secondary carer's role; there isn't sufficient learning, that informal learning is not adequate. Ms C mentioned that there is a need to create a different culture and a primary centre would be part of it. *(In defining a role of a new education centre - ambitious goal.)*

NB supports this widening of the learning repertoire *(perhaps surprising level of good insight into learning needs and also how to change the learning profile).*

Dr A makes a comment about CPD for GPs. This again would require a long-term change by investing time and money and perhaps LIZ will provide sufficient evidence that government will invest more. *(Change of culture, seeing needs from outside, moulding or trying to mould.)*

4 APPENDIX FOUR - REFLECTIONS ON A MEETING

COMMENTS:

On meeting's process - appeared to be identifying problems and finding solutions; share perspectives; part of dissemination process - but note hitches in organisation - South London not informed in time...

Individual's motivation to attend - not clear - to learn, to clarify ideas, to identify opportunities, to be seen to be there/ part of the process.

On whole initiative (attempt at first line analysis):

management perspective:

when there is a will there is a way - original idea (mine) 3 years ago was sabotaged by DoH and RCGP - now political imperative is driving it.

Essentially this is a natural experiment - throwing money and seeing what happens - 'garbage can' model of management. Answers appear to be structural, less process orientated (due to time scale) - unless it will unfold.

Political model - struggle between FHSA, regional advisers, academic units (but where are the GPs?)

culture perspective - with background political change of FHSA taking on more central, managerial role - need for collaboration between Educationalists and managers (but note that audit is also becoming management driven); is it becoming accepted that general practice is in process of continual change - can most GPs face it? Issue of recertification - change from liberal/ professional-led education to accountability; this links with potential threat to guaranteed employment.

Features of learning organisation - Meeting is just a snapshot in a process. Discovery of rules during process, learning by mistakes. Commissioning/ purchasing as learning by doing (well - reflection-in-action...)

Features of innovation - need for leadership, consideration of gain/ loss, of conflict, who are the change agents - have they got skills? Product is reputation of general practice - to attract and retain GPs - quite a intangible concept.

Motivation for change - external and internal, is there sufficient internal motivation/ are GPs aware that there is a need to move with times to new, market/ policy driven era?

Adult learning features (or lack of) - learning need assessment - whose - learner-led or manager led, mentorship (& portfolio/ profile), facilitators, ? practice-based, IPE - starting from common need.

Other issues identified:

no career structure for GP - how to maintain motivation and interest;

FHSAs will join with DHAs - unitary organisations with loss of structured medical advice from GP viewpoint;

5 APPENDIX FIVE - AN EXTRACT FROM THE LIST OF CODED EXTRACTS

5. IPE

5.1 need for IPE

There is a need to rationalise the educational provision of the expanding numbers of courses, particularly at post-registration level, possibly with a move towards more multi-professional education, and by the various higher education institutions involved with primary care education so as to achieve equivalence.

(Health authority education advisory group minutes)

Alternative/ contrary view

(In developing LIZEI; my questions) Will supporting structures be adequate, will they duplicate existing ones? Will there be conflict between the aims of educationalists and managers (FHSA)? Political model - struggle between FHSA, regional advisers, academic units (but where are the GPs?) Little mention of IPE, teambuilding.

(Field notes - Education Board meetings)

5.1.1 Shift of power

One reason why IPE is prevalent at the moment is that it is right – it is the way forward, but I fear that why it's fashionable at the moment is because you have people jumping on what they call the politically correct bandwagon. It's a fashion and that worries me greatly. This is a wonderful thing which if it is dealt with on that basis will be gone in five years – certainly the Great and the Good we're talking about – they will have moved on to the next fashion and that worries me because I think this is crucial to our future development – as a group of professions.

(GP educator 2)

NHSE wants to see an equalisation between all the staff groups within the health service. It wants to see effectively everyone dealt with on the same basis, totally at local level, without any necessary recognition. But there are different needs – there are uniprofessional issues as well as multiprofessional ones.

(GP educator 2)

And so what we are actually developing at the moment is a core curriculum - or a common pathway - that registered nurses upon registration and junior doctors can follow. Because it doesn't make very much sense to have about five or six different institutions within a different area all doing the same thing when we're fighting for the same resources, when we can actually do it ourselves within one given institution, and obviously this underpins - this is on the back of junior doctors' hours - there's no getting away from that, with the current emphasis being on the reduction of junior doctors' hours.

(Nurse educator 1)

Multiprofessional education is about preparing practitioners to operate within a multidisciplinary context in the clinical environment. This requires a new set of skills and they centre on how professionals interact with one another in the clinical environment. One of these is the ability to deliver their skills within the organisation's business plan to which they have contributed. This touches on how professionals form teams, how they plan together and make decisions together within the clinical context. Identifying the skills needed and the appropriate point at which to introduce them is important. Continuing professional education has traditionally been about honing own professional skills and it needs to concentrate more on the skills needed to interact.

(Medical education manager 3)

5.1.1.1 Demolish uni-professional knowledge mystique

My vision of the future is that a number of energetic individuals from a variety of professions will stimulate the places that they work in, plus other groups, other primary care teams, to become learning organisations. And that these learning organisations will be independent and dependent at the same time. They will be independent in looking at their own learning needs but dependent to a certain extent on using outside educational resources .

(GP educator 1)

The multi-professional learning experiences in view from the patient perspective would be beneficial because professionals would have a much more rounded view, where people present with symptoms/problems and we talk a lot about holistic approach, you can't have that approach, unless you have quite broad grounding and broad experience.

(Lay person)

I think also professionals have to realise that they have to broaden their knowledge-base, and to some extent that has come about by the need to reduce the specialisation and make people or enable people to be able to contribute more widely to whatever their profession is, rather than have to fit in narrow bases and sub-specialities - very narrow sub-specialities.

(Lay person)

In the same way the professional bodies are not looking to give a commitment to IPE because it would threaten their professional definitions and boundaries. There is still feeling abroad that learning with others and changing traditional attitudes is not respectable.

(Medical education manager 1)

The majority of skills that were previously undertaken by junior doctors or even registrars are now being undertaken by nurse practitioners and other members of the multidisciplinary team.

(Nurse educator 1)

The courses we put on are for everybody, regardless of whether they're a consultant, health care assistant, dishwasher, or whoever it may be. Say, for instance, I want a basic life support course. I will get physiotherapists, occupational therapists, secretaries from the typing pool, personnel officers - anybody - regardless of their path. We make the assumption that the individuals know nothing, so they are all trained to the same standard.

(Nurse educator 1)

All courses and conferences on cystic fibrosis and a recent textbook contain multiprofessional input. Similar models can be developed for other disease. No one person can have all the skills required by patients with cystic fibrosis, a life-threatening chronic disease. The days of doctors as gods have long since gone.

(Nurse education advisor 4)

Knowing how someone is trained enhances your participating in their teaching and how to place their contribution within the team. It is important to understand the limitations of others' training and their knowledge about your specialty and their levels of clinical responsibility. It is also important to recognise and value the specific contribution of others' training and the perspectives it brings. There is a need for some core training - sitting down in a seminar room with professionals from other disciplines - as this would enhance inter-professional working.

(Professional body officer 3)

An attempt to outline philosophical basis of IPE (for undergraduate courses) - analyse different professional philosophies/ approaches to practice - is there a common base? Issues - student- ,

patient- centred, reflective practitioner. And the usual - tension between academic philosophy and professional ideology (who has the power?)
(Field notes - IPE conference)

Alternative/ contrary view

If people learn together at any stages in the learning process, it's very beneficial because nurses would then, for example, have a perspective of medical perceptions, doctors would have a perception of a nursing relevance, etc. And then you wouldn't have this situation where doctors decide what is appropriate for a psychologist .
(Lay person)

This priority (of promoting IPE) does not imply a threat to existing professional qualifications or to independent professional self-regulation. Rather, it seeks to stimulate the development of shared learning where this will benefit subsequent professional practice and where joint education and training will be more cost-effective.
(NHS Executive, 1995a)

5.1.1.2 Need to evaluate - EBM/ E

It's something we take on as an act of faith at the moment. We're told that it is good and right by the Great and Good as it were. The first thing we need to do is to establish whether it really is good, whether it really is beneficial. The thing really with multiprofessional working – I mean I know it is, on an instinctive, feeling basis, but I think we probably do need to formalise that to an extent.
(GP educator 2)

An independent client outcome measure is needed such as that developed by Professor Wing. This would be useful in promoting multiprofessional audit and learning instead of rivalry.
(Nurse education advisor 2)

Group suggested that there is a need for a research into the areas of appropriateness and effectiveness of multidisciplinary working models .
(Field notes - SCOPME meetings)

The group felt that suitable research should be undertaken because, as they noted; there is lack of an evidential base as to the efficacy of multiprofessionalism.
(Field notes - SCOPME meetings)

CAIPE is very keen to encourage others to look at how the practice of people who have been on such courses is affected, and what service users and patients feel about whether the courses have enhanced the service as they perceive it. We are not aware of any research that has followed the steps through to that stage.
(IPE champion)

One of the barriers holding people back is that there does not appears to be a consistent academic base about how learning together is best done.
(SCOPME meeting minutes)

If the intention is to promote multiprofessional education surely it would be better to tackle that promotion rationally gathering experience and evidence and making an appropriate case for it.
(Professional body officer 2)

There is very little evidence that inter-professional education achieves more than conventional education. This may be because of lack of investment in starting and evaluating initiatives but it

may also be because the outcome measures are not appropriate. For example, if the outcome measures are all medical, then the impact of other professions will be hard to measure. A more holistic approach may be needed including measures of quality of life and an appropriate usage of all services.

(Professional body officer 2)

Alternative/ contrary view

The problem with the way the NHS and professions within are moving (towards evaluating learning) is that people know the cost of everything and the value of nothing.

(GP educator 2)

5.1.2 Adult learning argument

So I went to the Chief Executive of the FHSA, this is when I was still a GP tutor and asked him for 25,000 pounds to fund a county-wide asthma course, make it multidisciplinary. But we were going to build in a third element which we felt was important, which was we wanted the people on the course to come as a team from a practice, a nurse and doctor, but we also wanted them to have a practice meeting as part of the course, back at the practice, to introduce the ideas they'd learned on the course and to discuss re-structuring of care, because the other thing we'd noticed was that lots of people told us stories about well, we know that there should be a protocol and you should do this and that in the practice, but the others won't do it, so we decided to put that in.

(GP educator 1)

Knowing how someone is trained enhances your participating in their teaching and how to place their contribution within the team. It is important to understand the limitations of others' training and their knowledge about your specialty and their levels of clinical responsibility. It is also important to recognise and value the specific contribution of others' training and the perspectives it brings. There is a need for some core training - sitting down in a seminar room with professionals from other disciplines - as this would enhance inter-professional working.

(Professional body officer 3)

Interprofessional working and learning is not about de-skilling and it is not about generic workers. It is really about recognising that in complex situations of health and social need, different skills are needed; that it is unrealistic and undesirable for one professional to have them all. It is therefore very much about people learning to collaborate and work in partnership, sometimes within teams, sometimes across teams and sometimes across organisations.

(IPE champion)

Sharing good practices which might advance IPE, such as learning need assessment for the whole team - facilitator going to practices interviewing (HVs, GPs, SWs, staff) re their perceptions of their roles in community care. On this basis they can develop meetings (and eventual training package).

(Field notes - CAIPE meetings)

5.1.2.1 Working together

How the advisory group fits in as a group or team (or whatever you want to call it), actually manages to put these various viewpoints together into some sort of coherent picture, is actually quite a good example of multi-professional working. It is often suggested that we should use that as a model.

(Medical education advisor)

One practice said we will try and have a plan now for our whole practice, rather than as individuals. They actually set up protected time, one and a half hours each week, and would have

had a meeting which would centre on education. So it was the primary healthcare team and at the first meeting they actually identified areas that they felt the practice needed to work on.
(Primary care researcher)

I think then if you had a lot of people from different professional backgrounds and varied learning sitting round having to make decisions on a certain thing, they would have different perspectives; that could enrich the decision-making process, because they could use - someone might have a module in psychiatry - and that would be very relevant to what they were considering.
(Lay person)

So I did that survey and I then realised that we needed to get away - people had very different expectations about what a primary care team was about - I had read so many articles on primary care but I could not actually see anywhere where they existed properly.
(Team facilitator 1)

What we do is on induction for junior doctors for instance, they will go and have an advanced life support course - they'll be taught how to cannulate, how to put necklines in, how to act as part of a team member in the resuscitation. They'll be taught about the protocols within the hospital with regard ordering goods and so on.
(Nurse educator 1)

5.1.2.2 Learning together

Doctors said at the end of the course was that they had actually learnt a lot from the nurses who were on the course from their approach to patient care because they cared for the patient and the doctors recognised that they actually cared for the condition that they were treating. Much more so. And that they had to open out and look at other areas and that was quite difficult for them because they'd never been taught that from the time they were 18, they'd been led down this narrow tunnel .
(Nurse education advisor 1)

Different parts of the system had different knowledge of community care - SWs more, health workers less so. Some GPs were keen to be involved , but others much less so - this was linked with their view of their role. How did we organise the team? We started with a problem solving group of GPs and managers meeting to discuss the results of the research I have done and trying to address the problems uncovered. An example could be the lack of knowledge of function and structure of social services department by GPs.
(Team facilitator 2)

Whilst GPs did not attend many sessions, this style of work-based learning was more valuable for the reception staff. We started with uni-professional groups to identify specific problems and then we merged groups together. What came up was a need for basic understanding of professional languages and underlying knowledge. For example for social workers it was useful to learn more about medicine. It then became possible to understand the adoption of different professional perspectives, such as definition of emergency.
(Team facilitator 2)

A debriefing period is always necessary following any critical event, simply because the members of the team need to know what happened. They need to know whether the initial treatment was effective; they need to know what the prognosis of the patient was; they need to know how well they did. Unless you reinforce team members of how well they responded, whether their approach was coordinated, what the outcomes of it were - you're just going away without any information and you are not actually getting any reinforcement that you need. Because if there was an error or an error of judgement, one should be able to sit down and say well maybe we should be looking at it from another viewpoint.

(Nurse educator 1)

Alternative/ contrary view

The current (multiprofessional) Master's in health sciences is build on medical model relying on scientific approach and epidemiology. There is little on interprofessional working, even two modules that would lend themselves to it - communication and decision making - are not enough. The students themselves have remarked how they do not benefit from expertise of the other professionals on the course.

(Nurse educator 2)

5.2 control of professions

5.2.1 Tools of power

It (IPE) comes from originally are the human resource people – that's where these ideas were originally being floated, in the HR people in the computer industry years ago – and the hi-tech industries and this whole way of working, and it's filtered through into the management structure and is perceived by those in professional organisations and academic organisations and government and latched on to as the idea of the day.

(GP educator 2)

The JCPTGP could play a role when inspecting practices for vocational training. The College (RCGP) could include inter-professional education in its curricula and a question about inter-professional working as part of its membership examination Inter-professional working could be include in its assessment of GPs for the college Fellowship.

(Professional body officer 2)

Alternative/ contrary view

I think a lot of this team building that's going on is founded on the wrong principle, that teams go believing that they're seen to be bad, or not very good at what they're doing, and I think that's wrong, I think they should be told to start with they're good enough or they're even better than good enough, to look positively at what they've achieved.

(GP educator 1)

5.2.1.1 Surveillance

Training sessions together are OK but there is a need for a follow-up, for an individual support to professionals to check what they are doing. Then you achieve change, as each professionals has a need for a follow-up in different way according to their personal situation - thus my approach can be adjusted.

(Team facilitator 2)

So I went to the Chief Executive of the FHSA, this is when I was still a GP tutor and asked him for 25,000 pounds to fund a county-wide asthma course, make it multidisciplinary. But we were going to build in a third element which we felt was important, which was we wanted the people on the course to come as a team from a practice, a nurse and doctor, but we also wanted them to have a practice meeting as part of the course, back at the practice, to introduce the ideas they'd learned on the course and to discuss re-structuring of care, because the other thing we'd noticed was that lots of people told us stories about well, we know that there should be a protocol and you should do this and that in the practice, but the others won't do it, so we decided to put that in.

(GP educator 1)

The course is more traditional now, it is basically didactic teaching, plus project work and some people don't do the project work, so they get points for the didactic teaching and the project work is essentially audit and then all the audit is amalgamated together so people can see how they're doing in comparison with the other people on the course.

(GP educator 1)

So for example, they (the primary care team) were interested in bringing in appraisals, and they had a facilitator in to talk about appraisal and from that they've gone on to deciding what means of appraisal would be most appropriate for that practice to introduce for everybody, doctors included.

(Primary care researcher)

Multi-disciplinary learning is very difficult. It's down to the lack of mutual respect. If you advertise such an event, GP's don't come. If you don't mention who it's for, GP's will come. If you advertise it for 'practice nurses and GP's', more practice nurses will come than if you'd advertised it for 'practice nurses'. You can sit in the room and see why - you can see a practice nurse asking a question, and you say, oh god, what a stupid question. On the other hand there are just as many questions that are quite illuminating, and every body wants to know the answer to. A GP is just as likely to put his hand up and ask a stupid question.

(Health authority manager)

Alternative/ contrary view

There is a great deal of suspicion surrounding the whole thing of appraisal from virtually anybody. Admin staff perhaps a little less so, because they're often reviewed by their practice manager already, they may not call it appraisal, but because they're used to the procedure there, they're not too bothered about it it's not a popular concept.

(Primary care researcher)

During the follow-up visits on progress on action plans made at team workshops, it wasn't the feeling that there's a big brother watching over them, it certainly wasn't that, if they feel that someone is going to be checking up on them. They obviously liked having that support.

(Primary care researcher)

5.2.1.2 Normalisation

What we do is on induction for junior doctors for instance, they will go and have an advanced life support course - they'll be taught how to cannulate, how to put necklines in, how to act as part of a team member in the resuscitation. They'll be taught about the protocols within the hospital with regard ordering goods and so on.

(Nurse educator 1)

The courses we put on are for everybody, regardless of whether they're a consultant health care assistant, dishwasher, or whoever it may be. Say, for instance, I want a basic life support course. I will get physiotherapists, occupational therapists, secretaries from the typing pool, personnel officers - anybody - regardless of their path. We make the assumption that the individuals know nothing, so they are all trained to the same standard.

(Nurse educator 1)

A debriefing period is always necessary following any critical event, simply because the members of the team need to know what happened. They need to know whether the initial treatment was effective; they need to know what the prognosis of the patient was; they need to know how well they did. Unless you reinforce team members of how well they responded, whether their approach was coordinated, what the outcomes of it were - you're just going away without any information and you are not actually getting any reinforcement that you need. Because if there was an error or

an error of judgement, one should be able to sit down and say well maybe we should be looking at it from another viewpoint.

(Nurse educator 1)

In the future , doctors, nurses, social workers, managers and other professionals will be required to work alongside and with each other to ensure a more 'holistic' model of health and social care delivery.

(GP postgraduate education committee minutes)

An attempt to outline philosophical basis of IPE (for undergraduate courses) - analyse different professional philosophies/ approaches to practice - is there a common base? Issues - student- , patient- centred, reflective practitioner. And the usual - tension between academic philosophy and professional ideology (who has the power?)

(Field notes - IPE conference)

Dr T outlined approaches to interprofessional learning at undergraduate and postgraduate level. He noted that professionalism, which includes expert, managerial, practical and reflective abilities, is increasingly questioned. In the future, a more generalist perspective to problem solving was likely, with a move away from specialism.

(CAIPE minutes)

Tribalism is a key problem and creates barriers. It results from stereotypical ideas about other professions, sex and class differences, differing educational achievements and rivalry between education centres. It can be counteracted by developing shared philosophies, structures, values and assessments and by promoting transferable skills.

(CAIPE minutes)

Professional, statutory and regulatory bodies could:

develop closer links and identify a common core curricula, common language and common code of professional conduct across all professions;

develop occupational standards that incorporate collaboration;

identify core shared competences and the overlap of activities between professionals;

develop joint accreditation processes which are accessible, flexible and quality driven;

rewrite the undergraduate curricula to facilitate and integrate interprofessional learning develop an educational framework that encourages interprofessional learning.

(CAIPE minutes)

CPD programmes must be developed according to reasonable criteria.

These are likely to embrace some measure or description of:

- life-long learning - an attitude to the importance of the continuing and all embracing nature of professional renewal;
- educational effectiveness;
- involvement of individuals and teams - breadth, depth and quality of coverage. This should include involvement over time, and in flexible careers;
- relevance of professional standards - both uni- and multiprofessional

(Calman, 1998)

Effective clinical teams should be prepared to test themselves against others providing similar care, to see where they stand and to learn from this. This testing can be quite informal - for example, through visits, discussions, and comparing results with colleagues. There may also be a more formal audit, involving an external review leading to accreditation for training.

(GMC, 1999)

6 APPENDIX SIX - CATEGORY STRUCTURE

1 NHS/ CONTEXT OF CHANGE

- 1.1 Imposition of change
 - 1.1.1 Need for control of professions
 - 1.1.2 Adoption by the professional bodies
- 1.2 Let markets triumph!
 - 1.4.1 Skill - mix
 - 1.4.2 NVQ
 - 1.4.3 Short contracts
- 1.3 Shift of power
 - 1.3.1 disciplinary power
 - 1.3.2 Bio-power
- 1.4 Tools of power
 - 1.4.1 Surveillance (accountability, monitoring),
 - 1.4.2 Examination
 - 1.4.3 Discipline (self-monitoring) , standards/ audit/ guidelines
- 1.5 factors for change
 - 1.5.1 Extra/ external factors
 - 1.5.2 Culture of organisation
 - 1.5.3 Gain/ loss
 - 1.5.4 Leadership

2 WHO NEEDS TEAMWORK?

- 2.1 need for teamwork,
 - 2.1.1 Different perspectives
 - 2.1.1.1 Managers
 - 2.1.1.2 Professionals
 - 2.1.1.3 Patients
- 2.2 achieving teamwork
 - 2.2.1 Altruistic
 - 2.2.2 Fear of loss of autonomy
 - 2.2.3 Support from management
 - 2.2.4 Leadership
 - 2.2.5 Climate for innovation
- 2.3 teamwork is more efficient!,
 - 2.3.1 Need for better/ more efficient care provision
- 2.4 let's control the professionals
 - 2.4.1 tools of power:
 - 2.4.1.1 Surveillance in teams
 - 2.4.1.2 Examination
 - 2.4.1.3 Contracts/ accountability
 - 2.4.2 Danger to clients

- 2.5 teams and IPE
 - 2.5.1 Teambuilding
 - 2.5.2 Learning organisation

3 CPD - WHOSE AGENDA?

- 3.1 need for CPD
 - 3.1.1 From government - support, life-long learning
 - 3.1.2 From managers - skills & flexibility
 - 3.1.3 From professions - voluntary, altruistic
 - 3.1.4 From professional bodies
 - 3.1.5 From educators
- 3.2 controlling professions
 - 3.2.1 Unpredictable behaviour - need to control the autonomy
 - 3.2.2 Technology of power
 - 3.2.2.1 Observation - data collection/ classification / portfolio
 - 3.2.2.2 Self-monitoring - Panopticon
 - 3.2.2.3 Normalisation - standard setting, revalidation, competencies

4 WORK-BASED LEARNING

- 4.1 need for/ move towards/ changing face of professional education
 - 4.1.1 Stakeholders perspective
 - 4.1.1.1 Managers
 - 4.1.1.2 Learners
 - 4.1.1.3 Educators
- 4.2 controlling professions
 - 4.2.1 Efficiency - service-linked education
 - 4.2.2 Surveillance - mentors, team learning

5 IPE - NEW KID ON THE BLOCK

- 5.1 need for IPE
 - 5.1.1 Shift of power
 - 5.1.1.1 Demolish uni-professional knowledge mystique
 - 5.1.1.2 Need to evaluate - EBM/ E
 - 5.1.2 Adult learning argument
 - 5.1.2.1 Working together
 - 5.1.2.2 Learning together
- 5.2 control of professions
 - 5.2.1 Tools of power
 - 5.2.1.1 Surveillance
 - 5.2.1.2 Normalisation

6 STAKEHOLDERS

- 6.0 Power and stakeholder interactions
 - 6.0.1 Policy making

- 6.0.2 Instability of power - fragmentation and competition
- 6.0.3 Perceptions of each other - respect & power
- 6.1 The manager group of stakeholders - new power locus
 - 6.1.1 Actions and intentions of the state - relationships with the other stakeholders
 - 6.1.1.1 Power instruments:
 - 6.1.1.1.1 Legislation
 - 6.1.1.1.2 Resources
 - 6.1.1.1.3 Accountability and quality assurance (QA)
 - 6.1.2 Actions and intentions of the health authorities and employers - policy implementation
 - 6.1.2.1 Link to state - command chain - influence both ways
 - 6.1.2.2 Implementation:
 - 6.1.2.2.1 negotiation, change agents etc.
 - 6.1.2.2.2 Resources - allocating, prioritising
 - 6.1.2.2.3 Developing common vision/ language
 - 6.1.3 Actions and intentions of the health authorities and employers - relationships with the other stakeholders on professional education.
 - Power and its manifestations
 - 6.1.3.1 Power struggle
 - 6.1.3.2 Competition or collaboration?
 - 6.1.3.3 Autonomy
 - 6.1.3.4 Increased control - Changing scene - educational consortia
 - 6.1.3.5 Move toward CPD
 - Changing roles
 - 6.1.3.6 Pressure from professional organisations (nurses) for profiling
 - 6.1.3.7 Trusts not supportive - resources/ time
- 6.2 Developing new control mechanisms - case of intermediate group in professional education
 - 6.2.1 Shift of power
 - 6.2.1.1 - motives
 - 6.2.1.2 - tools of control:
 - 6.2.1.2.1 resources
 - 6.2.1.2.2 Documents - common culture
 - 6.2.1.2.3 Negotiation
 - 6.2.1.2.4 Accountability
 - 6.2.2 Structural changes:
 - 6.2.2.1 Old - RA
 - 6.2.2.2 New:
 - 6.2.2.2.1 Case study of educational consortia
 - 6.2.2.2.2 Educational manager
 - 6.2.2.3 GP tutor structure

- 6.3 Professions under siege
 - 6.3.1 deprofessionalisation/ shift of power.
 - 6.3.2 Individual professional - Professional autonomy threatened
 - 6.3.2.1 Challenge to autonomy of professional organisations
 - 6.3.3. Freedom is not acceptable
 - 6.3.3.1 need accountability
 - 6.3.3.2 inappropriate choice of learning
 - 6.3.3.3 inadequate need assessment
 - 6.3.3.4 managers taking over
 - 6.3.4 Perspectives:
 - 6.3.4.1 Altruistic
 - 6.3.4.2 Critical
 - 6.3.5 Professional organisations - vanguard in power struggle
 - 6.3.5.1 Accept changing environment
 - 6.3.5.2 Setting entry criteria
 - 6.3.5.3 Seen as having leadership role
 - 6.3.6 Motives - Defending professional boundaries & autonomy
 - 6.3.6.1 Delay in introducing IPE
- 6.4 Education as a market
 - 6.4.1 System view -
 - 6.4.1.1 Changes in professional knowledge
 - 6.4.1.2 Remit of professional work
 - 6.4.1.3 Technological advances
 - 6.4.2 Pluralist
 - 6.4.2.1 Shift towards market orientation
 - 6.4.2.2.1 Post-technocratic
 - 6.4.2.2 Competition or collaboration?
 - 6.4.2.2.1 flexible response - better organisation
 - 6.4.2.2.2 Courses - new
 - 6.4.2.2.3 - incl NVQ
 - 6.4.2.2.4 Collaboration - multisite education
 - 6.4.2.3 Resources
 - 6.4.2.4 QA
 - 6.4.3 Impact
 - 6.4.3.1 Negative
 - 6.4.3.2 Positive - an opportunity

DISCOURSES

7 DISCOURSE OF MANAGEMENT

- 7.1 emergence
 - 7.1.1 motives of managers
 - 7.1.1.1 break down professional barriers
 - 7.1.1.2 service is paramount!
- 7.2 Discourse and control of professions
 - 7.2.1 professions become 'object'
 - 7.2.1.1 workforce planning
 - 7.2.1.2 accountability
 - 7.2.1.3 measurement - time, effort, movement
 - 7.2.1.4 efficiency drive - VFM
 - 7.2.2 discourse of power
 - 7.2.2.1 mutual influence between discourse and societal change
 - 7.2.2.2 docile bodies - control of population
 - 7.2.2.3 professions as docile bodies
 - 7.2.3 resistance in discourses
- 7.3 Role of CPD and IPE
 - 7.3.1 Learning for better service
 - 7.3.2 research into service
 - 7.3.3 devolution of responsibility
 - 7.3.4 accountability
 - 7.3.4.1 punishment
 - 7.3.5 adoption of discourse by professionals
 - 7.3.6 learning organisation/ reflective practice
- 7.4 Policy-making in CPD and IPE
 - 7.4.1 discourse of teamwork and IPE

8 INTERMEDIATE GROUP

- 8.1 DA proper
 - 8.1.1 micro-processes - discursive practices
 - 8.1.2 macro-processes - social practices
- 8.2 Building blocks
 - 8.2.1 power-knowledge in system - need for change
 - 8.2.1.1 complexity of providers
 - 8.2.1.2 need for efficiency
 - 8.2.2 language (of management), motives, tools
 - 8.2.2.1 common culture
 - 8.2.2.2 shared vision
 - 8.2.2.3 mixing management and adult learning discourses

9 DISCOURSE OF PROFESSIONS/ EXCELLENCE

- 9.1 Building blocks
 - 9.1.1 need for professional autonomy - to create docile bodies
 - 9.1.1.1 altruistic view of professions
 - 9.1.2 structures as impact of discourses
 - 9.1.3 specialised knowledge - classification of population
 - 9.1.4 interpenetration of discourses
 - 9.1.4.1 use of professional/ excellence discourse by management
 - 9.1.4.2 of management by professionals
- 9.2 Impact of discourses - Constructing
 - 9.2.1 professional as a learner
 - 9.2.1.1 as a deviant need of control
 - 9.2.2 as an educator
 - 9.2.2.1 need to move away from personal development
 - 9.2.2.2 need to control professionals through them
 - 9.2.3 Constructing professional body
 - 9.2.3.1 penetration of management discourse
 - 9.2.3.2 role in governance of professions - manager' need

10 DISCOURSE OF ADULT LEARNING

- 10.1 components
 - 10.1.1 respect for learner
 - 10.1.2 equality of power with facilitator
 - 10.1.3 experiential learning
 - 10.1.4 relevant to context of learner
 - 10.1.5 group learning
- 10.2 dilemma of discourse
 - 10.2.1 critique
 - 10.2.2 colonisation by discourse of management
- 10.3 in CPD/ IPE
 - 10.3.1 hidden from learners
 - 10.3.2 colonisation
 - 10.3.4 commodification
 - 10.3.4.1 market
 - 10.3.4.2 flexibility
 - 10.3.4.3 QA

7 APPENDIX SEVEN - TEN FEATURES OF QUALITATIVE RESEARCH AND THEIR APPEARANCE IN MY RESEARCH

The purpose of this section is to provide further justification of using grounded theory method, as according to this argument adherence to these principles (Tesch, 1990) gives it robustness and methodological validity.

1. **'Analysis is not the last phase in the research process; it is concurrent with data collection or cyclic.'** The main feature is the absence of linearity of the process that characterises the traditional positivist research, with its conceptualisation of the link between cause and effect, between the postulation of a research question and the execution of the research itself.

This was the case in my research, where the analysis began to inform the data collection and helped to refine the research question.

2. **'The analysis process is systematic and comprehensive, but not rigid.'** It is necessary to approach the inquiry in a disciplined, rigorous and organised way. The final shape of the analysis and its product is not set in advance, but develops as the analytical process continues until the data stops yielding any new ideas.

The discipline was present in the way I approached the analysis of the data. All the material was examined in detail, and the process of identifying new elements and the links between them became more focussed once the structure of the themes began to firm up.

3. **'Attending to data includes reflective activity that results in a set of analytical notes that guide the process.'** The reflective activity was the mainstay of this research process. To capture it, the working memos helped to track the development of ideas and the potential links between the different sources of data.

It was during this process that two aspects emerged as relevant to the future direction of the research and the analysis. First, a need to specify who were the important stakeholders and what were their functions and roles. Second, an emerging striking issue was the use of language that appeared to differ in some ways between the stakeholders. This influenced the direction of the second part of the analysis by bringing in discourse analysis.

4. **'Data are segmented, i.e. divided into relevant and meaningful units.'** It was helpful to subdivide the data during the analytical process into digestible chunks (individual sentences or a number of them) for the purpose of comprehension and location of the building blocks of the content. However, the whole of the data set had to be read iteratively to retain the sense of the whole.

Flexibility and open-mindedness about the boundaries of such segments was required and was linked to the emerging category structure - this again underlies the need to revisit the data as the analysis proceeds.

5. **'The data segments are categorised according to an organising system that is predominantly derived from the data themselves.'** The category structure was built up progressively, from bottom-up, with, as mentioned before, the emerging hypotheses about linkages informing this inductive process. The developing research questions contributed to the categorisation as well.

For example, one of the first interviewees, while describing the work of primary care professionals, mentioned how fundholding began to change their interrelationships. Thus to start with, the initial,

free-standing category referred to the impact of fundholding on professionals with a potential link (annotated in a memo) to a wider context of the NHS changes. The link to education was unclear at this stage.

6. **'The main intellectual tool is comparison.'** One of the key characteristics of grounded theory (Strauss & Corbin, 1990) underpins many qualitative approaches. A continuous comparison involves checking the allocation of data to the emerging categories, discerning the similarities and differences between the categories themselves, and testing out the strength of the links between the levels in the category system. It also allows a progressive definition of the theoretical connections between the categories, and the discernment of the inherent patterns present in the data.

For example, in an early draft of the category allocation the issue of professional revalidation or recertification was allocated to the higher order category of 'legislation'. On further reading, other categories emerged that belonged to another higher order category 'management of change' and on review it became more logical to place the 'revalidation' issue under this heading.

7. **'Categories for sorting the segments are tentative and preliminary in the beginning; they remain flexible.'** Lack of rigidity in category structure is essential to accommodate the inevitable changes that consideration of additional data will reveal.

A good example of this process is how the category 'the stakeholders' became one of the key organising themes towards the later part of the analysis. To start with the individual stakeholders appeared under different headings - such as the education structure or NHS changes. Later, it became necessary to dis-aggregate all the references to stakeholders and group them together, while still making clear conceptual links to the original contextual issues.

8. **'Manipulating qualitative data during analysis is an eclectic activity; there is no one 'right' way.'** Tesch suggested that it is important to avoid rigidity in data analysis, and that it is not possible or even desirable to follow a recipe style approach.

It is thus possible, if someone else approached the body of the data, even with the final shape of the research questions in mind, that the process and the product of the analysis would differ in some important aspects. While someone else might agree on the validity of some of the objective issues, it is the interpretation of the data, identifying the relative importance of various elements, that is personal.

9. **'The procedures are neither 'scientific' nor 'mechanistic'.'** This characteristic augments the one articulated above. The right balance needs to be maintained between the demand of a systematic, competent and honest approach and the need for inventiveness and insight.
10. **'The result of the analysis is some type of higher level synthesis.'** The end result is not the atomic description of the positivist researcher, but more of an interlinked picture that allows new light to be shed on the area under investigation. This picture, by its nature, is complex as it needs to reflect the complexity of the real world.

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